Independent Investigation into NHS Scotland

Mr Mike McKirdy

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Foreword

Scotland's health service stands at a defining moment. It has many unique strengths — a strong record on quality and safety, pioneering public health initiatives, a workforce committed to providing high-quality care to their patients. Yet the reality for too many patients and staff is one of delay, fragmentation and strain. The challenge for Scotland echoes that facing health systems around the world: how to turn ambition into a system that consistently, equitably and sustainably meets the needs of those it serves.

Over the past few months, this independent review has examined the performance and direction of the national health service in Scotland. Following my independent investigation of the NHS in England in 2024, I was asked to advise the team leading this analysis and bring learning from that experience to bear — in the hope that it might open up a similarly honest conversation, and help identify where to focus recovery and reform efforts. As with the review in England, my aim was to apply the rigour of a clinician's approach to diagnosis — asking what is working well, what is not, and why.

What emerges is a picture of both pride and pressure. Scotland's health service remains rooted in the founding values of the NHS, but it is operating in a very challenging environment. The population is ageing faster than the rest of the UK, with more people living longer in poorer health. Life expectancy has fallen behind the rest of Western Europe, avoidable mortality has stalled, and economic inactivity due to ill health has reached a twenty-year high. These are not just abstract statistics but the lived experience of communities across Scotland.

As this report sets out, the signs of systemic stress are clear: long waits for treatment, falling public satisfaction, and persistent inequalities in access and outcomes. Despite rising investment, a growing workforce and the best efforts of dedicated professionals, the system is struggling to convert more resources into better results. Too much of the budget remains tied up in hospital care, too little in prevention, primary and community care.

High-quality care is never a fixed achievement — it must constantly adapt to meet new expectations, new pressures and new opportunities. My hope is that this analysis provides the foundation on which to improve. As this review makes clear, the key is implementation: putting well-evidenced policies into practice. Urgent action is needed now to address deficits identified here, such as lack of capital spend, in order to deliver better health and care for the people of Scotland in the decades to come.

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Introduction and Summary

The NHS is a treasured institution. Its founding principle, that care should be free at the point of need, remains deeply valued in Scotland. In many ways, the NHS acts as a symbol of our shared life and community. That it should be there for us at the start of life, all the way to the end, is a unifying and equalising concept. Its staff are proud of the work they do and the care they give is valued and respected by the public.

Yet, as the service comes under increasing pressure, these principles are becoming strained and frayed. As confidence in the NHS to be available declines, so too the commitment to the sharing of the risk of ill health and the common good of our shared life is in danger of becoming lost.

In conducting this independent review, I have therefore sought to assess the current state of the National Health Service in Scotland and the decisions that have led to this point. The purpose of this analysis is to clearly lay out the challenges facing any incoming is to clearly lay out the challenges facing any incoming Scottish Government which seeks to improve the performance of health services, as well as the priority areas for action.

In doing so I have sought to mirror as far as possible the approach taken by Lord Darzi in 2024 in his thorough investigation of the National Health Service in England. That was a deep and totemic piece of work, and I have appreciated his time and advice in undertaking this task. While, by necessity, this review is based entirely on data which is already publicly available, the conclusions are nonetheless as robust and evidence led.

The report considers many aspects of the performance of the NHS in Scotland, from patient access to the quality of services, the governance arrangements and productivity. It considers hospital activity, emergency and repeat admissions, delayed discharges, patient safety, avoidable mortality, preventive health measures, and inequalities in outcomes. Any health system must operate within its own specific context and so the report also considers the wider health and inequalities within Scotland and the role of prevention.

Decisions about how to address the challenges facing the NHS lie with Ministers, politicians and Parliament. Nonetheless, in this report I set out my independent assessment of what I believe to be key themes that need to be considered, and consequences of past decisions from which lessons should be learned.

My findings contained within the report are summarised below:

1. The scale of poor health and inequality in Scotland means that the need for a functioning universal health service is as great as it has ever been.

Scotland has the lowest life expectancy in both the UK and Western Europe. Not only are people dying younger, but they are also spending a greater proportion of their shorter lives in poor health. One in five Scots take antidepressants and nearly half self-report living with at least one long-term condition. Scotland also continues to face among the highest rates of "deaths of despair" in Europe, with drug deaths remaining at crisis levels.

Weak economic growth has compounded health challenges. Since the 2007-08 financial crisis, median household income, after housing costs, has grown at just 0.3% per year, with poorer households falling further behind. Nearly one in four children — around 240,000 — and 37% of young adults aged 16–to-24, now live in relative poverty. These economic pressures drive ill health, increase demand on health services, and weaken resilience across communities.

Employment is a key determinant of health and life chances. Yet an increasing number of working-age Scots are leaving the workforce due to poor health. More than 7% are now economically inactive for health reasons — the highest level in over two decades. Particularly worrying is the doubling in just six years of young people aged 16–24 out of work or education due to ill health. This shrinking healthy workforce further constrains productivity and service capacity.

2. The health service in Scotland has not adequately adapted to changing need and societal developments. This failure has led to a decline in the ability of the system to deliver for the Scottish people.

The scale and type of demand on the NHS has changed, both from when it was established but also in the past 20 years.

We have an ageing population. The number of people aged 65 and over has increased 42% since 2000 and 2.4% of the population are now aged 85 and over. From some perspectives this can be seen as a success of the NHS. More people are living longer and surviving illnesses that would previously have been fatal, but this, in turn, is increasing demand on health and care services. For example, by age 85, around four in five people live with at least one chronic illness, most with multiple conditions.

Wider society has also changed. There are improvements in technology and subsequent changes in lifestyles and workplaces. This has implications for public health and the interventions that are possible. But it also means that how people engage with services and where they get their information from has changed.

Yet, the NHS in Scotland has failed to keep pace and adapt. It is still trying to deliver the same services under an outdated model of care. The result is a short-term, fire-fighting approach that is not delivering the long-term improvements that Scotland needs.

3.   The challenges in the NHS were not caused by the Covid-19 pandemic. The inability of the system to deliver was evident before 2020 across a number of performance measures.

Waits for urgent and planned care, diagnostic services, and even initial contact points such as NHS 24 were all lengthening before the arrival of the Covid-19 virus.

A&E departments have not met the 95% standard for patients to be seen within four hours since August 2017. Attendances have remained broadly stable over the past decade and so this decline cannot be explained simply by rising demand. In 2014, only 0.6% of patients waited more than eight hours and 0.1% more than 12 hours. By 2019 those figures had risen to 1.3% and 0.3%, respectively.

The median wait time for an NHS 24 call to be answered had increased from 9 seconds in 2014/15 to over 5 minutes in 2019/20. By 2019/20, only 67% of ambulance call outs to potentially life-threatening cases arrived within 10 minutes, down from 85% in 2012/13.

Outpatient activity peaked in 2014/15 and since then both new and return attendances have trended downwards. Performance against the standard that 95% of patients should be seen within 12 weeks for outpatient appointments had been declining since 2012, falling to 77% in March 2020. Between July 2012 and March 2020, the waiting list for CAMHS grew by an average of 27% per year. Elective inpatient treatment referrals were declining pre-pandemic but performance against the Treatment Time Guarantee was steadily worsening. In 2013 almost all patients were treated within 12 weeks of the decision to treat, but by December 2019 less than 72% were meeting the target.

As well as longer waits, there were signs of a wider system under pressure. Delayed discharges are a well-recognised marker of system inefficiency and poor patient experience. Before the pandemic, despite promises that delayed discharges would be eradicated, the number of discharges that followed a delay rose gradually from just under 5,000 per month in 2017 to over 6,000 at the start of 2020 (Figure 26).

4.   The Covid-19 pandemic and the measures taken to address it did, however, expose and enhance the impact of existing weaknesses.

The Covid-19 pandemic was a challenge for every health service around the globe. Yet, its effect and ongoing impact within Scotland are inevitably linked to the weaknesses and issues that were prevalent within the health service here before the arrival of the Covid-19 virus.

For the NHS in Scotland, the Covid-19 pandemic was a catalytic moment. Although the NHS responded to the emergency, caring for patients and saving lives, it only managed to do so by initially stopping huge volumes of other activity. This has continued to have lasting impacts that the outdated NHS model is unable to tackle.

There have also been lasting impacts from the pandemic beyond the build-up of unmet need that occurred during the lockdowns. The experience of the pandemic accelerated various factors:

- Experienced people retired or left the NHS workforce and health boards now carry higher levels of sickness absence among the workforce.

- Efforts to support healthy habits within the population have been set back, such as support for vaccination.

- Changes made to access arrangements, for example in GP and A&E, have been made permanent even if they do not benefit patient experience.

Gains which were starting to be realised before the pandemic – in delayed discharge, improved healthy habits, vaccination, efficiency in unplanned care have also all been lost.

5. Unsurprisingly, a health and care system that was unable to meet demand prior to the pandemic has proven incapable of recovering.

There are more patients waiting to see a specialist that ever before. As of June 2025, there were 570,000 waits for an outpatient appointment and, since December 2019, growth has accelerated, with an additional 4,400 patients being added to the list every month. The elective treatment backlog also continues to grow, with just under 160,000 people on the waiting list in June 2025. Numbers waiting over the past year have reached their highest on record and performance against the Treatment Time Guarantee has been declining, with the average treated within the 12 week guarantee around 57% since December 2022.

The number of patients waiting extreme lengths of time is also rising. In June 2025, 9% had been waiting more than a year for their first outpatient appointment. Longer waits risk not only delaying treatment but worsening patients' health, leading to greater need by the time they are finally seen.

Since 2022, performance against waiting standards for diagnostic tests has declined. Overall, only about 50% of tests are completed within six weeks, with endoscopy performance hovering around 40%. Waiting lists have grown accordingly. By December 2024, the radiology waiting list was 88% higher than in December 2017, while Endoscopy waiting lists had increased by 36%.

Since this analysis was completed there have been signs of some small increases in hospital activity and reductions of waiting lists. While this does show that improvements can be made, activity remains well below pre-pandemic levels and waiting lists remain significantly higher than they were, both pre-pandemic and a decade ago.

Acute hospital services are under strain. Attendances at A&E have returned to pre-pandemic levels but in 2024, 11.2% of patients waited over eight hours and 5% waited over 12 hours. Patients are also staying longer once admitted, limiting throughput and tying up scarce beds. Delayed discharges have surged, now accounting for around 14% of hospital capacity, up from 10% before Covid-19, with delays lasting a third longer. While acute beds appear stable on paper, rising lengths of stay and delayed discharges mean fewer patients can be treated. Occupancy rates for acute beds now exceed 90% in medical specialties — well above safe thresholds — leaving the system vulnerable to gridlock.

Official waiting time targets for mental health services are being met on paper, yet this masks a reality where antidepressant prescribing is at record highs and 'deaths of despair' continue to climb. Meeting narrow waiting-time standards does not guarantee adequate care.

Against this backdrop, more people are turning to private healthcare — since 2019/20, private admissions have risen by 55%. This trend risks entrenching a two-tier system where access depends increasingly on ability to pay rather than clinical need.

6. **Despite the respect and priority given to the NHS as a policy issue by both Scottish politicians and the wider public, the task of grappling with how to adapt the system so that it delivers for the needs of the Scottish people in the 21st Century has not been tackled seriously.**

Small tweaks have been made to delivery of care, such as NHS111 and Pharmacy First. However, because these have been bolted on and not adequately connected to forecasts of demand or a wider vision of universal access at point of need, the added capacity they have offered has merely been swallowed up and failed to relieve pressure elsewhere.

The NHS has numerous targets and measures a huge amount of data related to patient journeys and experience, but it is not clear how this is being used to improve services. Public satisfaction with the NHS has fallen dramatically, from around three in five people pre-pandemic to only about one in five today.

The Scottish Government has a Digital Health and Care Strategy, but digital access and use of technology to enable efficiencies have lagged progress elsewhere. In primary care there has been some shift toward virtual consultations, with now 18% of appointments being carried out remotely. More broadly though, while a digital app for NHS primary care services has been available to the

public in England since 2019, full public rollout of an app in Scotland will only commence in 2026, with full implementation not anticipated until 2030. Similarly, rollout of e-prescribing in Scotland was only due to be completed by 2026, while GPs in England have had fully digitised prescribing since the 2010s.

Governance is fragmented with 14 territorial health boards, 31 integration authorities, and multiple national bodies operating under tight central government controls. This complex structure means reforms and improvements are difficult to roll out at scale or pace, while accountability and transparency are made easier to avoid.

7. Reforms have been driven more by the desire to be seen to be doing something in response to specific problems, rather than connected to a wider vision for a modern delivery of care.

Since 2007, more than 130 major strategies have been published — roughly one every seven weeks.

The current Scottish Government created a number of new targets after they first came to power in 2007 – the 12 week Treatment Time Guarantee being the most well-known. But these new targets were not followed up with targeted resources and instead were left to health boards to deliver within budget.

Attempts at wider system change have focused more on process than changing service delivery. The recent attempt to create a National Care Service collapsed due to a prioritisation of process and structural reform, as opposed to a focus on removing the drivers of poor quality care.

Safe staffing legislation created new frameworks for analysing what staffing levels were required for quality care, but this was not matched with a coherent workforce plan and training places for staff, rendering the work ineffectual at achieving tangible change.

The integration of health and social care created numerous new public bodies and shuffled staff but overlooked the real causes of the problems it was seeking to address – namely the lack of social care and the overly complex bureaucracy causing delays to hospital discharge.

8. A defining feature of Scotland's health and care system is the gap between policy ambition and delivery.

Media cycles reward strategy launches over delivery, further crowding out implementation. The result is a system where the right answers are known but not consistently acted upon.

From the Kerr Report in 2005 to the Feeley Review in 2021, the vision of shifting care into the community has been widely endorsed but only partially implemented. Despite years of stated

ambitions to "shift the balance of care" from hospitals to the community, the system remains hospital centric.

This is despite hospital use reflecting and reinforcing deep inequalities. People in deprived areas are more likely to attend A&E, be admitted for emergency care, and rely on hospitals due to poorer underlying health and barriers to early intervention. In rural areas, geographical isolation and weak community care provision exacerbate inequities.

Political dynamics add further complexity. With limited capacity and political energy absorbed by wider crises and constitutional debates, long-term health reform has lacked consistent follow-through.

9.   While years of austerity undoubtedly made an impact on services, insufficient attention has been paid to what money has been *spent on*, rather than simply *how much* has been spent.

Compared with England, Scotland has historically spent more per head on health, though the gap has narrowed in recent years, from around 17% in 2006/07, to just 2% by 2023/24. In recent years, the Scottish Government has satisfied itself that it is providing resource, without adequately asking whether funding is going to the correct places. The result is that while spending has increased, outcomes for patients have not improved to a comparable extent.

Annual budgets, earmarked funding, and short-term performance targets reinforce hospital-centric crisis management at the expense of prevention and community support. Hospital services still account for more than half of health spending, while family health services such as general practice have seen their share fall by a quarter since 2005/06. In real terms, spending on primary care has barely risen despite rising demand from an ageing and more unwell population.

Capital budgets have shrunk as a share of total spending, limiting investment in infrastructure and equipment. Diagnostic capacity is particularly constrained. Scotland has fewer MRI and CT scanners per head than international comparators, and many machines are beyond their recommended lifespan.

The NHS workforce has grown substantially. Since 2010, medical and dental staff numbers have increased by 38%, with consultant numbers rising by over 40%. Nursing numbers have also expanded. Crucially, though workforce growth has not translated into higher productivity. Hospital activity is lower today than in 2018 despite more consultants and nurses.

10.   The result is that NHS Scotland is in the grip of a productivity squeeze – there is more spending, more staff but this has not delivered more care.

Scotland lacks a single headline productivity measure like those published by the Office for National Statistics (ONS) and NHS England. However, the evidence suggests NHS is delivering less care for more input than it did just a few years ago.

Before the pandemic, NHS productivity in hospitals was rising slowly, driven by more admissions and shorter average length of stay. The Covid-19 pandemic brought that to a halt. Despite record levels of spending and a growing workforce, the productivity of the health service has stalled. Additional funding has sustained activity but not transformed capacity.

Rising demand, longer stays, delayed discharges, and ageing patients mean that additional staff and resources are absorbed by complexity rather than converted into more care delivered. Instead of pushing more resources into hospitals, policy needs to focus on removing the blockages in prevention, primary care, and community-based care services.

Scotland's health service faces a structural paradox: Scotland has more staff, more funding, and more policy initiatives than ever before, yet patient outcomes and experiences are stagnating or even declining. Inequalities persist, public satisfaction is falling, and productivity has stalled.

11. **The workforce is the system's greatest resource, but also its most fragile. The NHS depends on a committed and highly skilled workforce but there are worrying signs that the pressures under which they operate put them at risk of burnout.**

Between 2010 and 2025, whole-time equivalent (WTE) medical and dental staff increased by 38%, with the rise largely driven by consultants and hospital based. Despite this expansion, shortages persist. Official statistics report around a 7% consultant vacancy rate, which others say could be even higher. The number of qualified nurses is up 14.8% from 2010 and 2025 but vacancies remain around 2,100 posts, roughly 4% of the workforce.

Retention is a growing concern. Around half of the consultants (43%) and nurses (54%) who left the NHS between April 2024 and March 2025 were under the age of 55. Sickness absence has risen from 5% in 2015 to 6.4% in 2025, with mental ill health a leading cause. Although not easy to capture in data, there are signs of morale problems that can be exacerbated by management's attempts to cope with demand pressure. A number of recent reports, including from Healthcare Improvement Scotland, have provided evidence of staff in some services operating under problematic cultures that actively discourage the raising of issues or shut down concerns even when regarding patient safety.

Reliance on temporary staff has escalated, with nearly 10% of nursing expenditure now spent on bank or agency contracts. This undermines stability and continuity of care while driving up costs. A cycle of stress, sickness, and turnover erodes productivity and service quality even when staffing numbers look adequate on paper.

12. **The current challenges are not insurmountable, but they do require a fundamentally new approach that ties both reform and resourcing to a vision for the future of the health service.**

It is entirely possible for the health service and the people of Scotland to thrive into the second half of this century – we have strengths in a number of crucial areas:

- A dedicated and talented workforce, motivated by the desire to care and improve the health of their patients.

- Deep and valuable connections with leading life sciences research and cutting-edge innovations.

- Evidence pre-pandemic that efficiencies and improvements could be made.

- A population still committed for now to foundational principles of universal health care, free at the point of need.

But to harness these strengths and to deliver the outcomes needed, serious change is needed in the direction and leadership of the health service.

Breaking this structural paradox within Scotland's health services — that of more staff, more funding, and more policy initiatives than ever before, alongside stagnating or declining patient outcomes and experiences — will require more than incremental reform. It demands a decisive shift toward upstream investment in prevention, primary care, and social care, alongside stronger governance, robust workforce and system planning, and a relentless focus on delivery.

If the aim is to save the NHS for future generations more of the same will not be enough.

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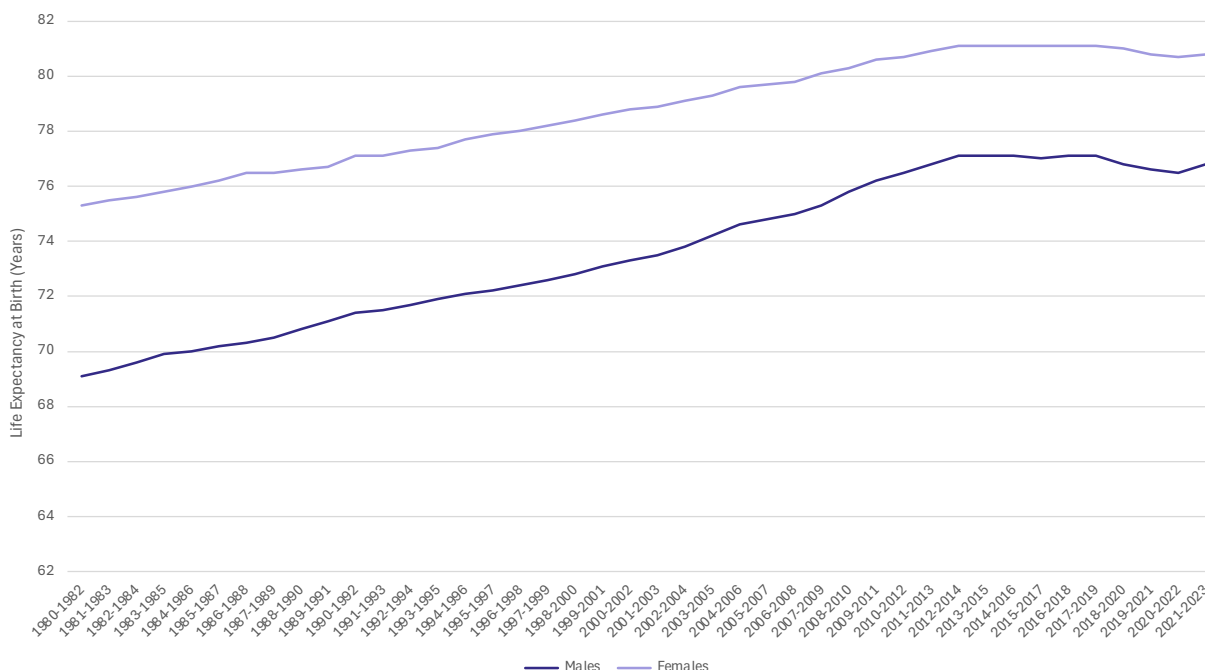# Part 1:

The Performance of the NHS in Scotland

Chapter 1.
Health of the Nation

Scotland has the lowest life expectancy — not only in the UK but also in Western Europe. Today, boys and girls are predicted to live around two years less than their peers in England [1]. Between 1980 and 2010, life expectancy rose steadily — one year gained every four years for males and every five years for females — but progress stalled after 2012 and reversed during the Covid-19 pandemic. Although recovery has begun, life expectancy remains below levels a decade ago, driven in part by rising mortality among 25–49-year-olds (Figure 1) [2].

Healthy life expectancy has also declined [3]. Scots now spend a greater share of their lives in poor health, particularly in more deprived communities. People in affluent areas live over a decade longer than those in the most deprived. Between 2021 and 2023, the healthy life expectancy gap between Scotland's least and most deprived areas was 24 years for females and 23 years for males [4].
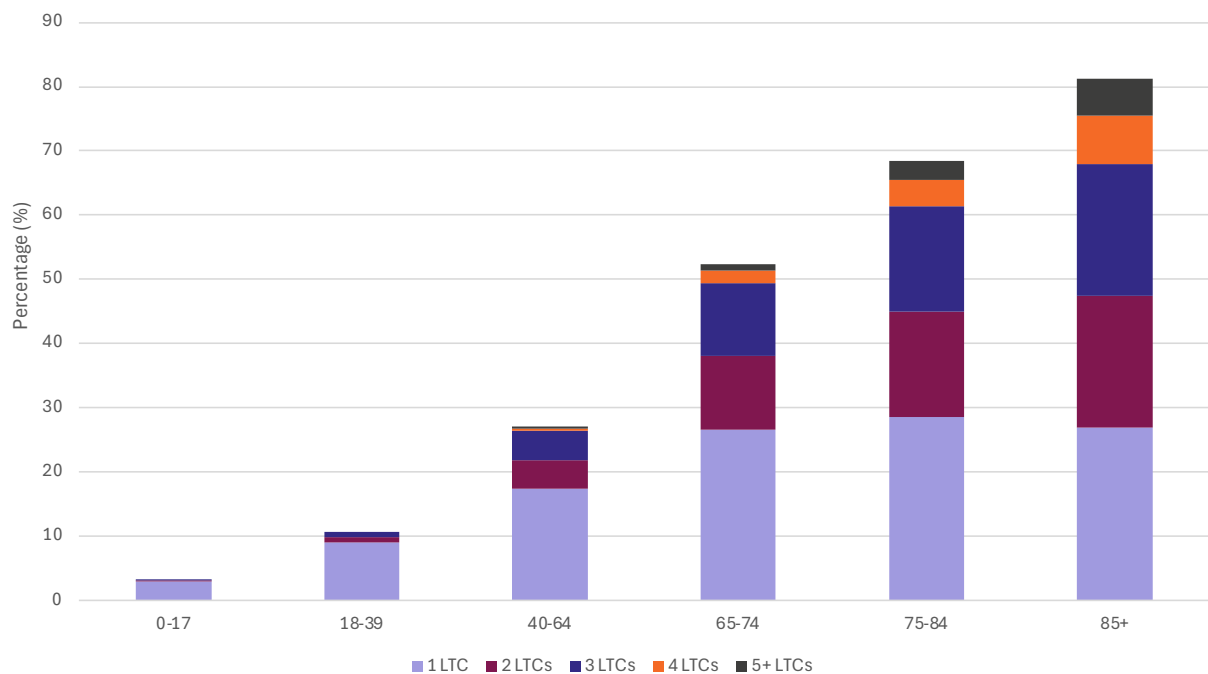
Figure 1. Life expectancy at birth

Source: National Records of Scotland, Life Expectancy in Scotland 2021-2023

Scotland's population is also ageing faster than the UK as a whole [5]. The number of people aged 65 and over has risen by 42% since 2000, reaching 1.14 million in 2024. 2.4% of all people are now aged 85 and over, up from 1.7% in 2000 [6]. Ageing is strongly associated with long-term conditions: by age 85, around four in five people have at least one chronic illness, with most actually suffering with multiple conditions (Figure 2) [7]. The most common are arthritis, cancer, asthma, heart disease, and diabetes. Only heart disease has declined in prevalence, with new cases of coronary heart disease falling by 12% between 2013 and 2022 [8]. As prevalence estimates for these conditions were derived from hospital and community prescribing records, they may be subject to underestimation, and it is possible that other conditions are more common. As more people live longer with multiple conditions, pressure on health and social care will continue to grow.

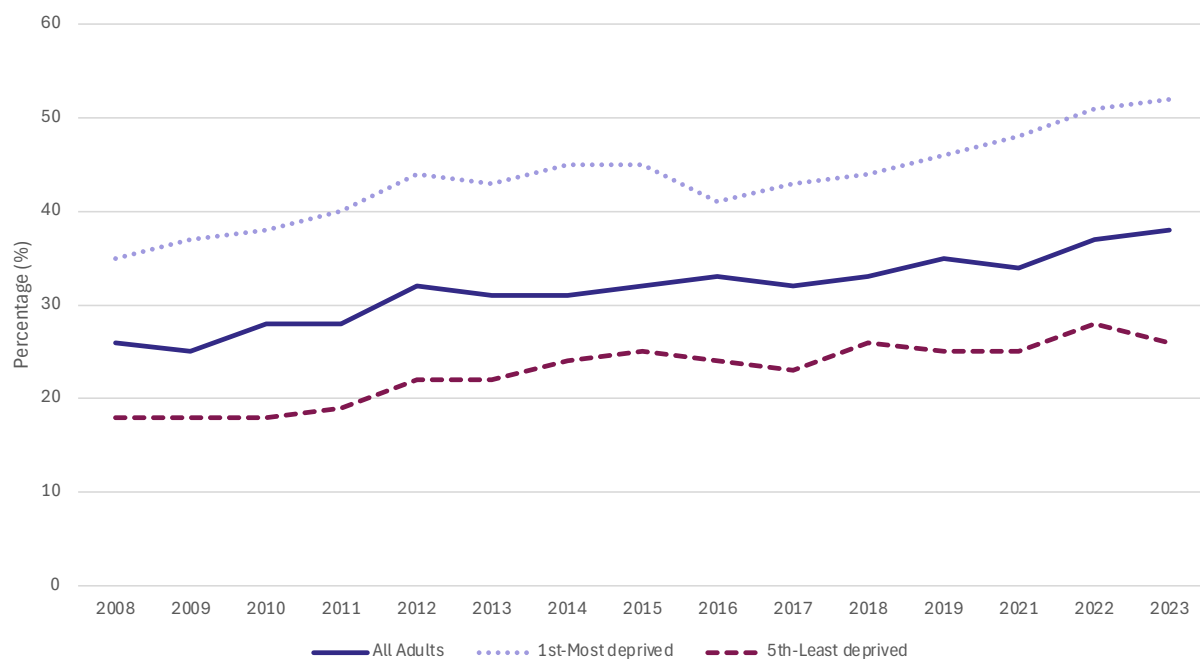*Figure 2. Proportion of age group with long term conditions*

Source: Public Health Scotland Information Request

Mental ill health is also rising. At least one in five Scots report symptoms of anxiety or depression [9], while prescribing data show that nearly one in five — over one million people — received antidepressants in 2024/25 [10].

Overall, about half the population self-reports having a long-term condition, with 76% describing it as limiting [9]. The burden falls disproportionately on deprived communities, where twice as many people report life-limiting illness compared to the least deprived (Figure 3).

Taken together, these demographic and health trends show a population that is older, sicker, and more complex in its healthcare needs. In 2023/24, far fewer people were low or non-users of health services than a decade earlier [11]. They also underline how patterns of behaviour and circumstance shape demand on the NHS.

Figure 3. Proportion of adult population with limiting long term condition

Source: Scottish Health Survey

Health Behaviours

Many long-term conditions are driven, or worsened, by lifestyle factors such as smoking, alcohol use, and obesity.

Adult smoking has fallen sharply in the past decade, from 22% in 2013 to 14% in 2023 [9]. But stark inequalities remain, with people in Scotland's most deprived communities more than four times as likely to smoke as those in the least deprived (Figure 4). Psychosocial stressors, such as poverty, insecure work, and poor mental health, are important drivers of this unequal uptake [12].

Hazardous alcohol consumption has also declined, falling 18% over the past decade. Still, more than a quarter of adults (28%) drank at hazardous levels in 2023. The 'alcohol harm' paradox persists — higher consumption among the most affluent (23% vs 17% in the most deprived quintile), but greater health and social harms amongst the most deprived communities [9].

Obesity, however, is moving in the opposite direction. One in three adults (32%) were obese in 2023, up four percentage points in 10 years. The burden is again unequal, with adults in the most deprived areas 44% more likely to be obese (Figure 5). By contrast, child obesity has remained broadly stable, with 17% of children at risk, unchanged over the past decade [9].

Physical inactivity is a major contributor. Around two in five adults (37%) fail to meet recommended activity levels, and one in five (22%) report very low activity [9]. Barriers include limited access to green space, the cost of organised exercise, and time pressures from work or caring responsibilities. In schools, initiatives like the Daily Mile pioneered in Scotland help sustain higher activity levels [13], with around 72% of children meeting recommended guidelines.

These behavioural risks both reflect and reinforce the wider social and economic conditions that shape health.
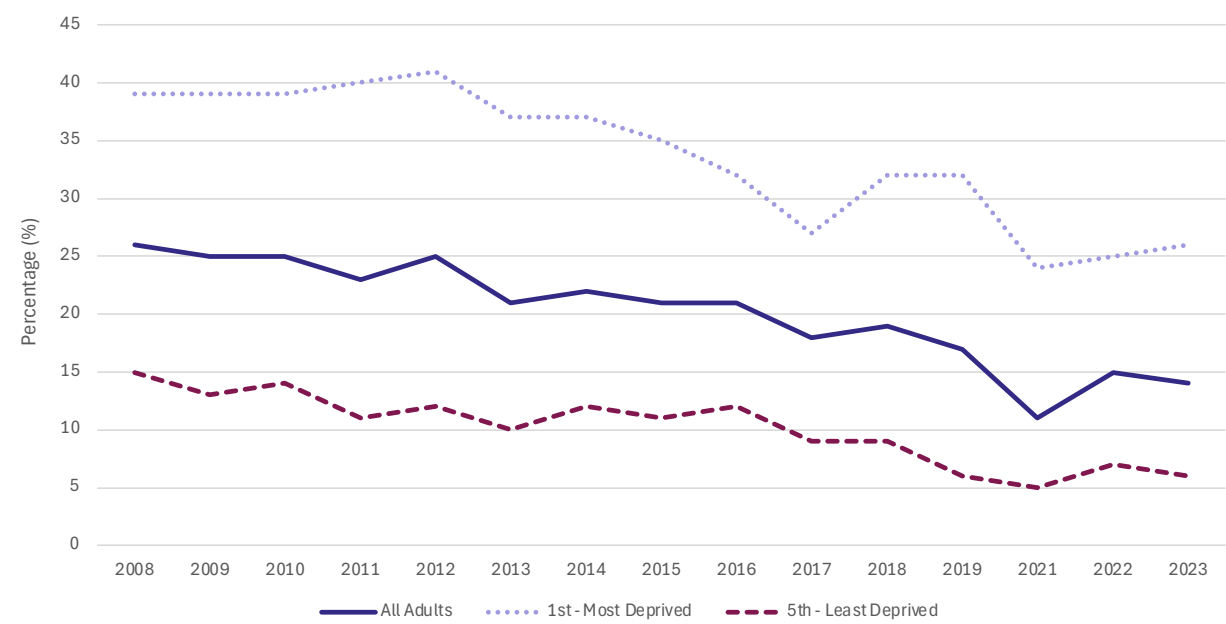
Wider Determinants

Stalled progress in health improvements over the past decade has been mirrored by stalled progress in living standards. While ageing is a major driver of rising healthcare needs, the nation's health is also shaped by wider determinants, including income, education, work, housing, community, and the physical environment [14].

Median household income after housing costs has barely shifted since the 2007–08 financial crisis, rising by just 0.3% per year over the past 14 years compared with 3.6% annually in the 13 years prior to 2007/08 [15]. The slowest growth has been among the poorest households. Nearly one in four children — about 240,000 — now live in relative poverty, and over a third of young adults aged 16–24 are also living in poverty (Figure 6) [15].

Food insecurity has grown alongside poverty. Approximately 14% of Scots report worrying about food running out by the end of the month, double the rate in 2017 [9]. Trussell Trust data show food parcel distribution has doubled in the past decade, from 119,000 in 2014/15 to over 239,000 in 2024/25 [16].
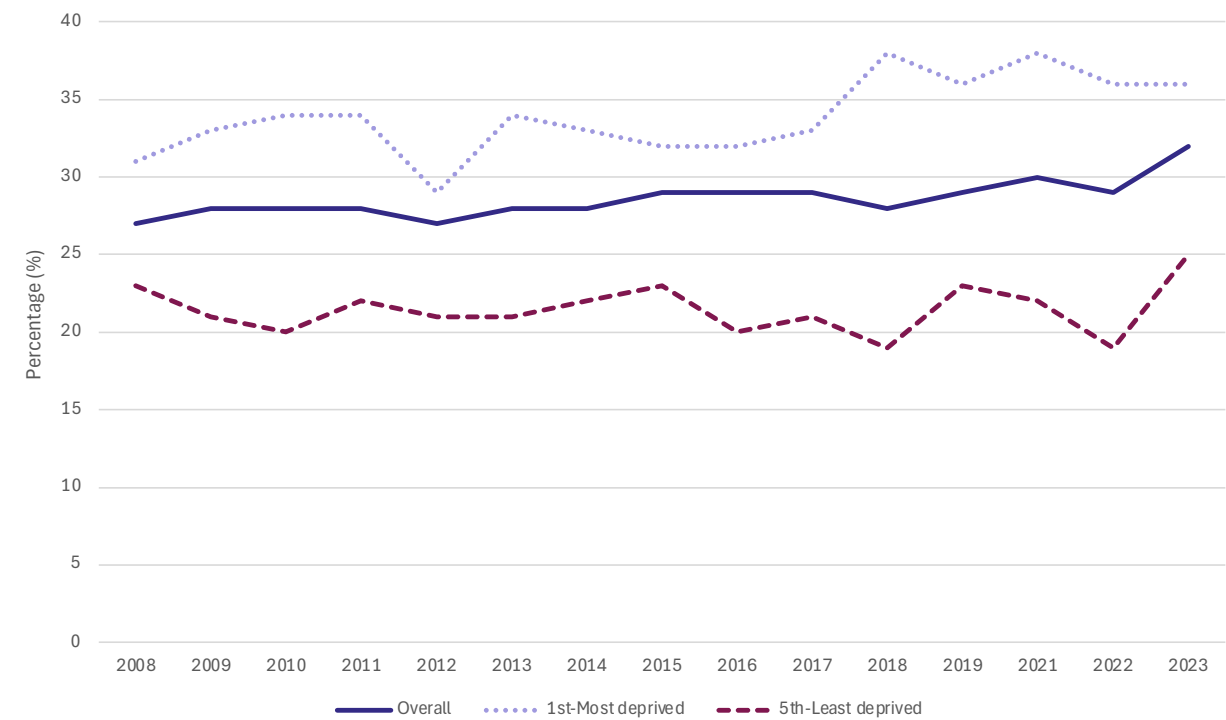
Poverty is also reflected in housing insecurity. In the 2023/24 report, 33,619 households were assessed as homeless or at risk, representing 53,549 people - including 15,474 children. The number of children in temporary accommodation has surged by 143% over the past decade, from 4,155 in 2014 to 10,110 in 2024 [17]. The absence of a stable home increases stress and is strongly linked to poorer outcomes in education, attainment, and later life chances [18]. Amongst individuals with homeless applications, the number who cite mental ill health has more than doubled from 2007/08 to 2023/24.

Figure 4. Proportion of adults who smoke

Source: Scottish Health Survey
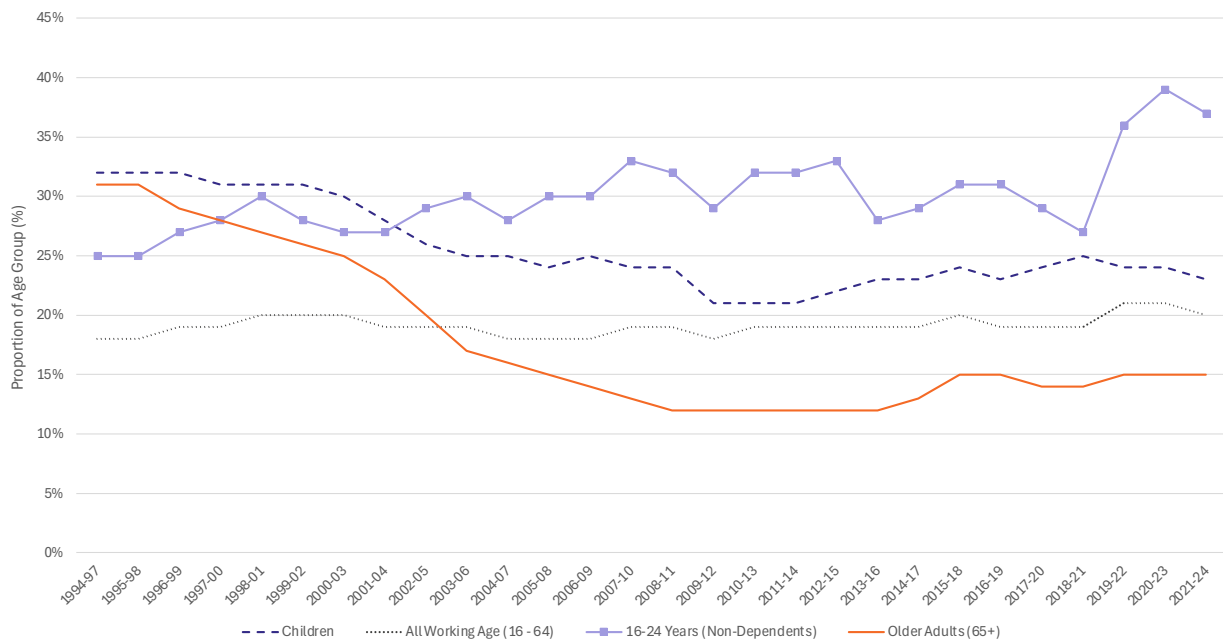
Figure 5. Obesity amongst adults

Source: Scottish Health Survey

Housing quality matters as well. Poor housing is associated with respiratory conditions and communicable disease [19]. Yet there has been no progress in reducing damp over the past decade. After modest improvements before the pandemic, both the private rented and social housing sectors have seen increases in damp and condensation problems. Privately rented households are nearly three times as likely to experience damp as owner-occupiers (Figure 7) [20].

Employment strongly influences health and life chances, but rising ill health is pushing more people out of the labour market. Over 7% of working age adults are economically inactive due to ill health, the highest proportion in over two decades. Worryingly, the number of young people (aged 16 to 24) out of work, or education, due to ill health has doubled over the past six years [21].
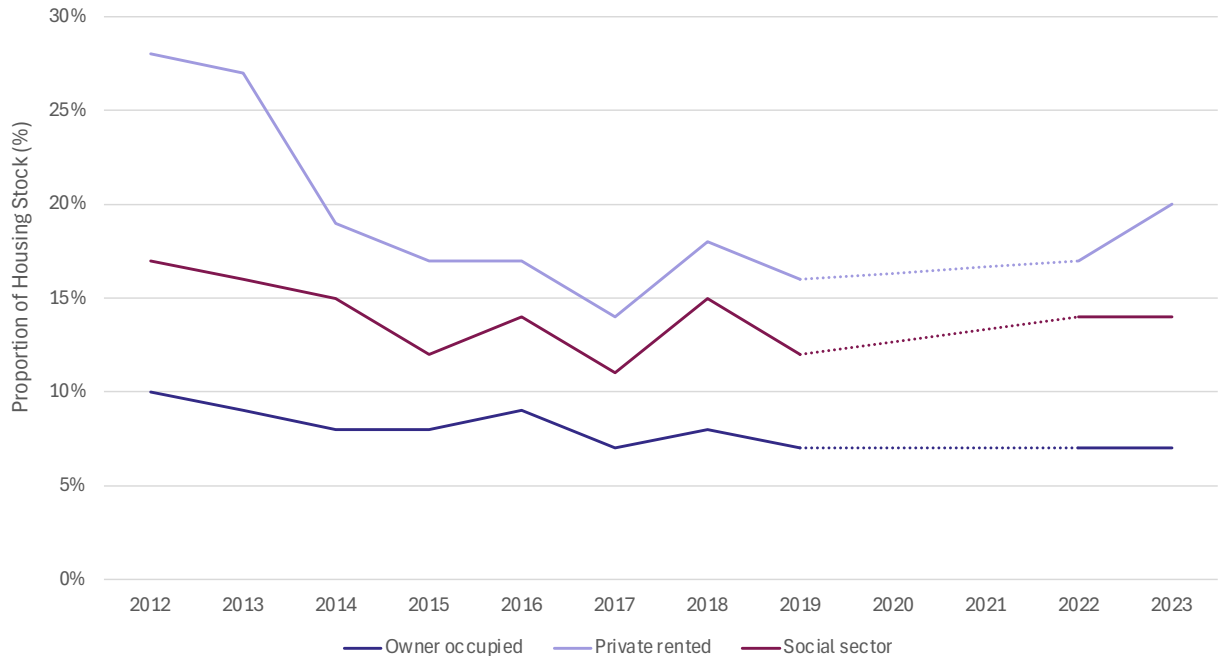
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Over the past decade, Scotland's health and living standards have largely stagnated. Life expectancy and healthy life expectancy have plateaued, inequalities in income, poverty, and housing persist, and lifestyle risks such as obesity remain high. An ageing population with increasing long-term health needs has contributed to steady growth in demand on the NHS — pressures which will be explored in the next chapter.

Figure 6. Relative poverty rates across age groups - after housing costs

Source: Scottish Government, "Poverty and Income Inequality in Scotland 2021-24"

Figure 7. Proportion of housing stock which contain damp and condensation, by tenure

Source: Scottish Government, "Scottish House Condition Survey"
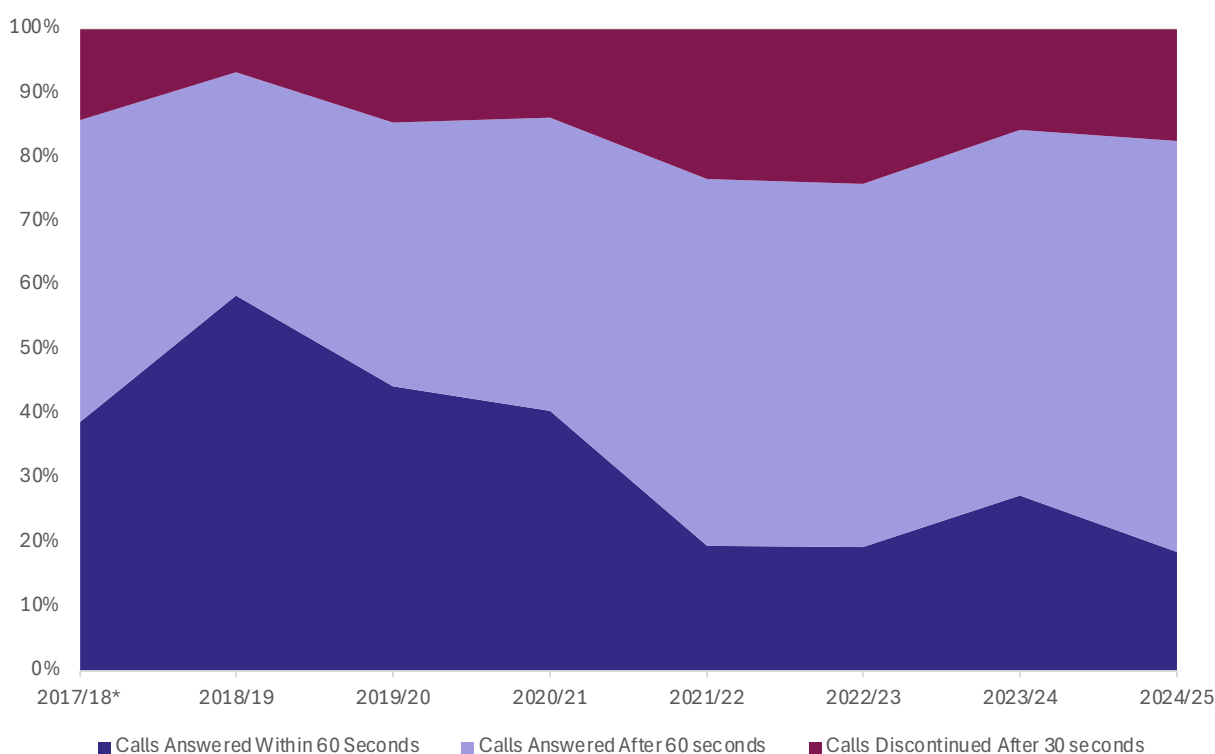
Chapter 2.
Access to NHS Services

This chapter examines the speed and ease of access to NHS services for patients - from first contact to hospital care. Access to timely care is a founding principle of the NHS, yet the scale of today's access challenges is often underestimated.

NHS 24

NHS 24's 111 service aims to connect patients with the right care, in the right place. In 2014/15 it handled an average of 140,000 calls per month, rising to 170,000 in the years immediately following the Covid-19 pandemic, but has since returned to pre-pandemic levels. Despite relatively stable call volumes over the decade, the system is under growing pressure. In 2024/25, 17% of calls over 30 seconds were abandoned, compared with just 1% in 2014/15 (Figure 8) [22].
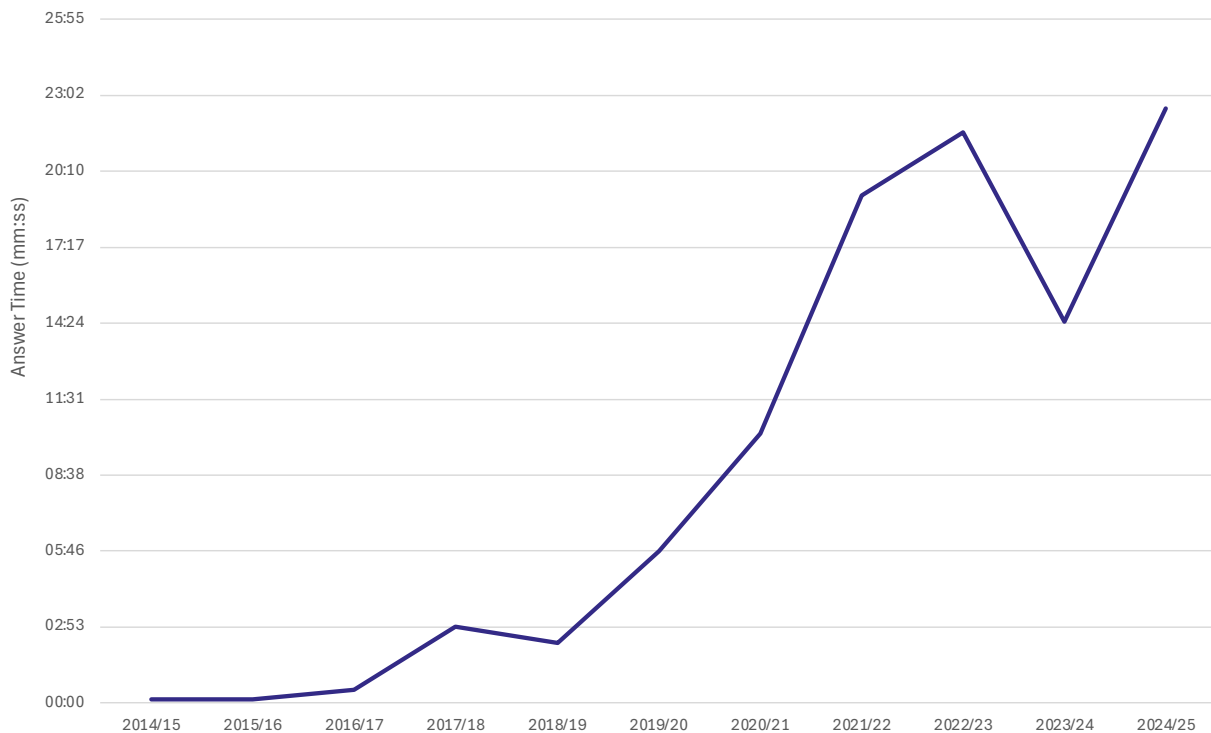
Figure 8. Call volumes split by answered in under and over 60 seconds and abandoned in over 30 seconds

Source: NHS 24 FOI Data

Average answering times have increased sharply, from 9 seconds in 2014/15 to 22.5 minutes in 2024/25 (Figure 9), indicative of a system under immense pressure. This may be partly due to long waiting times and a failure to meet demand elsewhere in the system, but it raises concerns as to whether the service is still reliably providing patients with the timely medical advice it is supposed to deliver.

Figure 9. Average time to answer NHS 24 calls

Source: NHS 24 FOI Data

Ambulance Services

Response times for life-threatening calls have lengthened. The Scottish Ambulance Service provides emergency care when immediate help is needed, categorising calls into four levels. The most urgent cases are those with at least a 10% chance of cardiac arrest, where every minute matters. Yet performance has deteriorated. In 2017/18, 81% of these calls were reached within 10 minutes, falling to 70% by 2024/25 [23].

For the two most urgent categories combined, the picture is similar. In 2012/13, 85% of urgent cases were reached within 10 minutes; by 2019/20 that figure had dropped to 67% and by 2024/25 it was 61%. Slower ambulance response times put lives directly at risk.
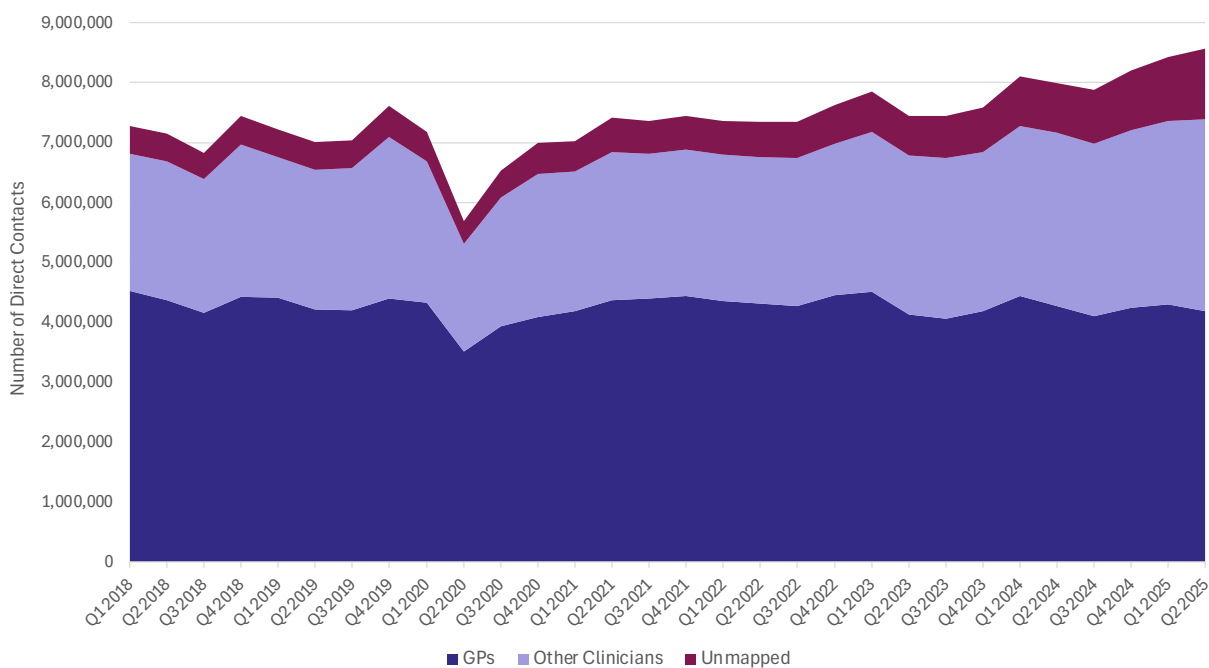
One major factor is hospital turnaround delays. In 2014, 55% of ambulance conveyances took more than 20 minutes to hand patients over to hospital staff; by 2024, this had risen to 91%, with nearly one-third taking over an hour. Over the same period, the median turnaround time more than doubled, from 21 minutes to over 46 minutes. With ambulances stuck at hospitals, they are unable to get back out into the community to reach people in need.

These pressures on urgent response spill over into primary care, where patients seek help when ambulances or urgent lines are unavailable.

Access to General Practice

General practice is the most common point of contact with the health service. Appointment volumes are at record levels, with GPs and their teams working harder and seeing more patients. In the first half of 2025, there were 2.5 million more direct contacts than in the same period in 2018, an 18% increase (Figure 10) [24].

Figure 10. Direct patient contact in general practice

Source: Public Health Scotland, "General Practice in-hours activity visualisation"

Part of this growth reflects the expansion of the general practice workforce. Increasingly, patients are seen not only by GPs but also by practice nurses, clinical pharmacists, physiotherapists, and

other specialists. In early 2025, 37% of direct patient contacts were delivered by this wider team, up from 32% in 2018.

Another driver has been the shift toward virtual consultations. Before the pandemic, only around 13% of appointments were remote. This rose to 40% at the height of the Covid-19 pandemic, before settling back to 18% in early 2025, still above pre-pandemic levels.

Despite higher capacity, access remains a challenge. In 2024, nearly one in four Scots (24%) reported difficulty contacting their GP practice in the way they wanted, and almost one in five (18%) said they had a negative experience arranging to speak to a doctor [25].

GPs also provide out-of-hours emergency care through GP Out of Hours services but despite rising demand generally, this activity has been falling. From 2014/15 to 2019/20, out-of-hours consultations fell by an average of 1.4% a year. Volumes surged during the pandemic, peaking in 2022/23 at 19% above 2019/20 levels — amounting to an extra 470 consultations per day — before returning closer to the pre-pandemic average in 2024/25 [26].

Access to Community Pharmacy

Community pharmacy is one of the most accessible parts of the health system. Unlike general practice, provision is more equitable, with over twice as many pharmacies located in Scotland's most deprived areas as in the least deprived [27].

Over the past decade, pharmacies have taken on a growing clinical role, from supporting minor ailments to dispensing methadone. The launch of Pharmacy First in 2020 has significantly expanded this role; between April-June 2021 and the same period in 2024, use of the service increased by 88%. In just three months between April and June 2024, it was accessed by nearly 800,000 people, around 15% of the population [28]. The more equitable provision of pharmacies presents possible options of expanding their role further and utilising their services in a greater diversity of health initiatives.

The total number of community pharmacies has remained broadly stable, falling by only 2% over the past decade [29]. But with an ageing population, rising demand, and the expansion of independent prescribing, there is a real risk that community pharmacy could face similar access pressures to general practice in the years ahead.

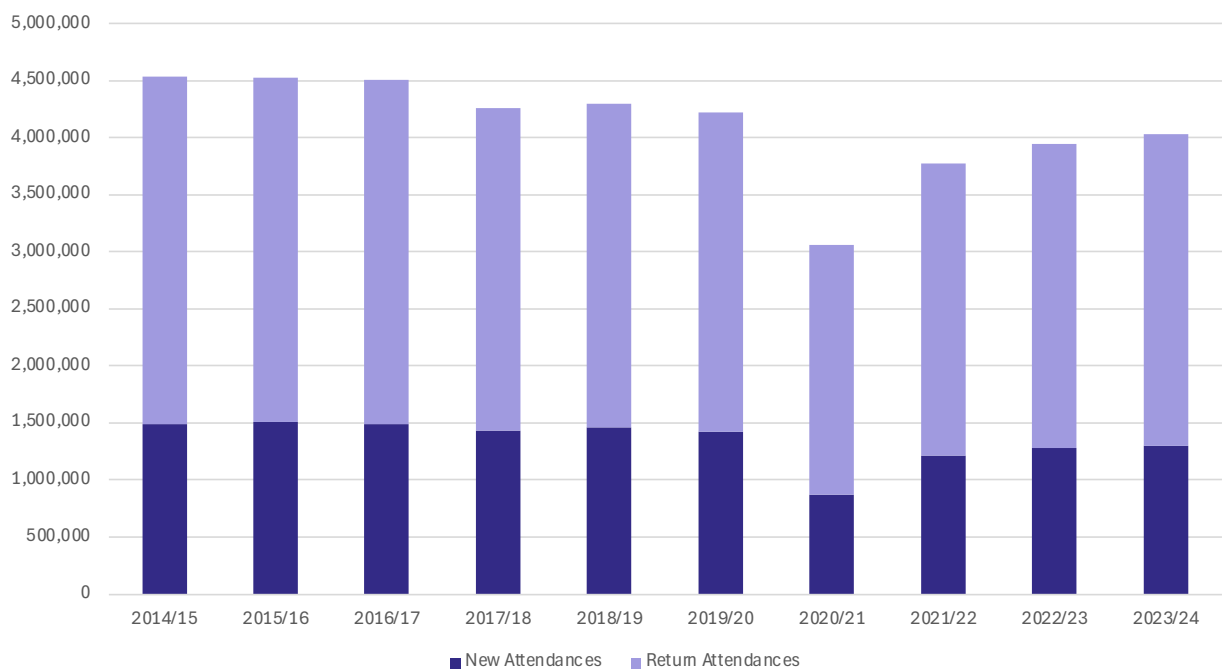**Access to Outpatient Services**

Outpatient Appointments

More Scots are waiting to see a specialist than ever before – there were about 570,000 outpatient

waits as of June 2025, equivalent to one in 10 of the population [30].

Outpatient activity peaked in 2014/15, when over 4.5 million appointments were delivered. Since then, both new and return attendances have trended downwards, a decline that began well before the pandemic. While volumes have started to recover, activity in 2023/24 was still only 95% of that delivered in 2019/20 (Figure 11) [31]. Reduced activity may be because of the NHS taking steps to reduce demand. The Scottish Government aims to eliminate 210,000 unnecessary outpatient appointments through the Centre for Sustainable Delivery [32].

This reduction in appointments might be sustainable if referrals had fallen in parallel. Instead, additions to the waiting list over the past year have returned to pre-pandemic levels, leading to growing backlogs. Between January 2013 and January 2020, the outpatient waiting list expanded by around 860 patients each month. Since December 2019, growth has accelerated, with an additional 4,400 patients being added to the list every month.

Figure 11. Outpatient attendances

Source: Public Health Scotland, "Acute hospital activity and NHS beds information"

As a result, Scotland is consistently missing its waiting-time standard. 95% of patients should be seen within 12 weeks of referral. Performance against this standard had already been declining since 2012, falling to 77% in March 2020. By June 2025, compliance had slipped further, with fewer than 65% of patients seen within 12 weeks.

The number of patients waiting extreme lengths of time is also rising. In June 2025, 9% had been waiting more than a year for their first outpatient appointment. Delays vary by specialty: 25% of patients referred to Endocrinology and Diabetes services had waited over a year, along with 16% in Ear, Nose and Throat, 13% in Gynaecology, 9% in Respiratory, and 4% in Cardiology. Some of these pressures reflect rising demand in chronic conditions, alongside limited capacity to expand services. Longer waits risk not only delaying treatment but worsening patients' health, leading to greater need by the time they are finally seen.

Child and Adolescent Mental Health Services

Between 2013 and 2023, referrals to CAMHS for children and young people under 18 increased by 53%. In 2024, there was a slight decline, with just over 34,000 referrals, of which around 25,000 were accepted for treatment. Despite more young people receiving care, the proportion of rejected referrals has risen in recent years; 27% in 2024, compared with an average of 21% between 2013 and 2019 (Figure 12) [33]. This increase may reflect limited alternative support services, leading to inappropriate referrals to CAMHS, or it could represent a mechanism to manage demand and waiting times.

The CAMHS waiting list in March 2025 was lower than at the same time in 2015. Between July 2012 and March 2020, the waiting list grew by an average of 27% per year, peaking in November 2021 during the pandemic. Since then, the list has declined, and by March 2025, the total volume was 32% lower than in March 2015. Nevertheless, over 3.5% of young people waiting for treatment, have now waited more than a year (Figure 13).

A slight reduction in accepted referrals since 2022 has coincided with improved waiting-time performance. The 18-week standard, which stipulates that 90% of children and young people should begin treatment within 18 weeks of referral, was met for the first time in August 2024. By March 2025, 94% of young people were being seen within this timeframe. However, a small number still wait over a year, and the persistently high rejection rate may continue to influence overall demand. This has also occurred alongside reports that health boards are changing or pausing referrals for young people referred for neurodevelopmental assessments, who may wait much longer [34].

Adult Psychological Therapies

In 2024, around 110,000 people were referred to adult mental health services, the lowest annual total since 2014. With the exception of 2020, referrals between 2018 and 2023 consistently averaged around 160,000 per year [35].

Performance against the 18-week standard, where patients should begin treatment within 18 weeks of referral, has remained broadly stable over the past decade, hovering around 80%. However, this

masks longer waiting times for some patients. The waiting list in March 2025 was approximately 41% larger than in March 2015. It grew steadily between 2015 and 2019, with approximately 2,700 people being added each year, peaking in 2019 with 28,000 on the wait list. Following a pandemic-related dip, the list has gradually risen again to just under 25,000 people.

Long waits remain a concern. In March 2025, 8% of patients had been waiting over a year, down from a pandemic-driven peak of 21% in 2021, but still substantially higher than in 2015, when fewer than 1.5% waited over a year.

Musculoskeletal Services

Since the pandemic, referrals to musculoskeletal (MSK) services have increased, with the majority — over 70% — for physiotherapy. In 2024, around 434,000 people were referred, slightly below the 442,000 referrals recorded in 2019 [36].

Rising demand has contributed to longer waiting lists. By March 2025, the MSK waiting list was approximately 67% larger than in March 2016. Despite this growth, the proportion of patients waiting more than four weeks for an appointment has remained relatively stable. Around half of patients are seen within four weeks, well below the 90% target.

MSK conditions are a leading cause of work-related absence and long-term sickness [37]. Delays in assessment and treatment can prolong pain and disability, limiting people's ability to work or engage in daily activities. Falling short of the four-week target therefore has implications not only for health but also for the economy, reducing workforce participation and productivity.
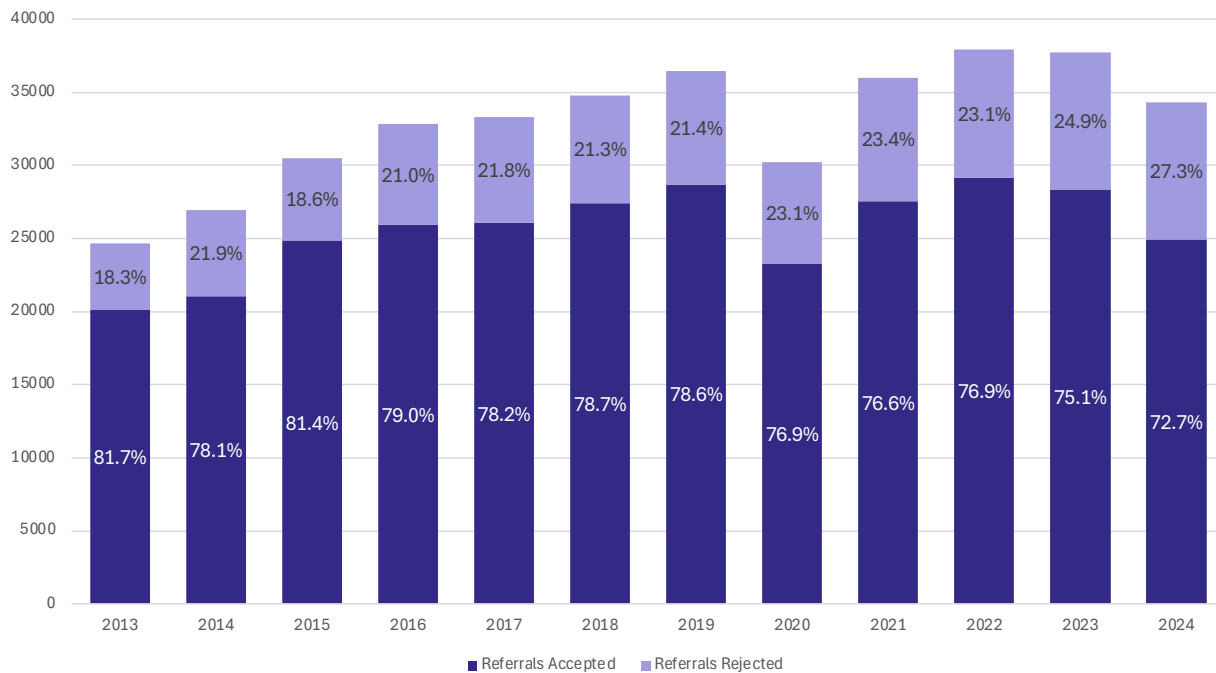
Diagnostic Waiting Times

Diagnostic testing is essential to ensure patients receive the most appropriate and effective treatment. Tests such as radiology scans or endoscopies provide the information that clinicians need to understand a patient's condition and determine the best course of care. Without timely diagnostics, treatment decisions can be delayed, less targeted, or less effective.

In the years leading up to the pandemic, around 80% of diagnostic tests were performed within six weeks of referral. This reflected a balance between increasing waits for radiology and reduced waits for endoscopy. Since 2022, performance has declined. Overall, only about 50% of tests are completed within six weeks, with endoscopy performance hovering around 40% (Figure 14) [38].
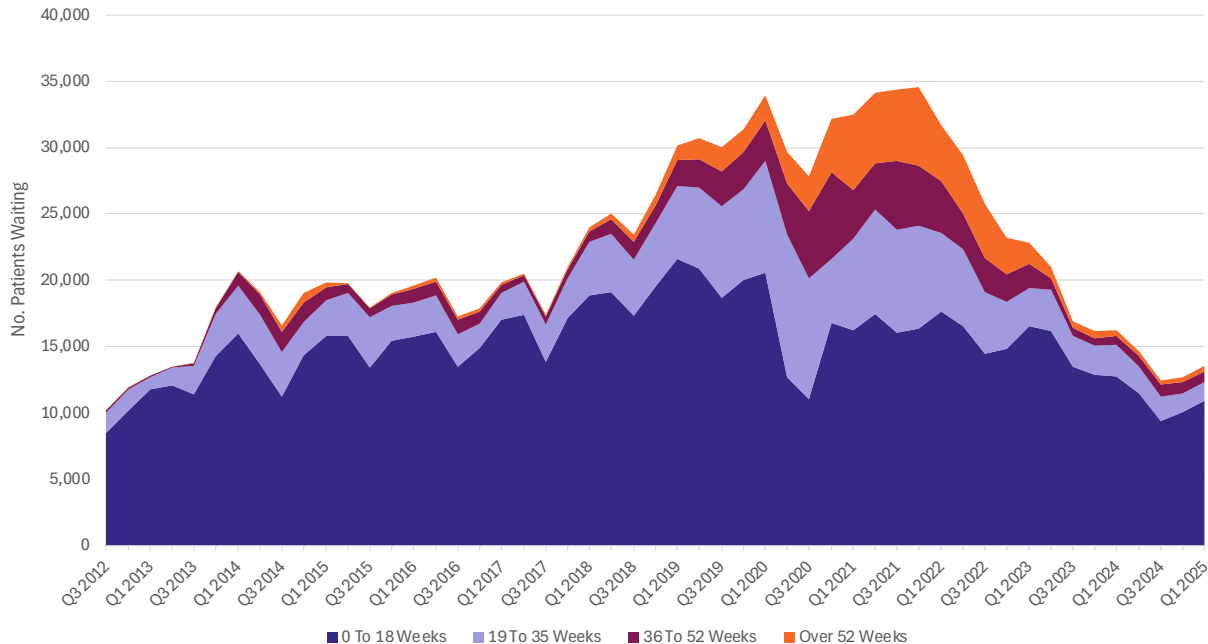
Waiting lists have grown accordingly. By December 2024, the radiology waiting list was 88% higher than in December 2017, with approximately 47,000 more patients waiting. Endoscopy waiting lists increased more modestly over the same period, by 36%, or about 9,000 additional patients.

Figure 12. Number of referrals to CAMHS services

Source: Public Health Scotland, "Child and Adolescent Mental Health Services (CAMHS) waiting times"

Figure 13. CAMHS Waiting List

Source: Public Health Scotland, "Child and Adolescent Mental Health Services (CAMHS) waiting times"

Extended waits for diagnostics can delay treatment, potentially worsening outcomes. Timely testing is not just about speed; it is critical for understanding each patient's condition and ensuring that subsequent interventions are both appropriate and effective.
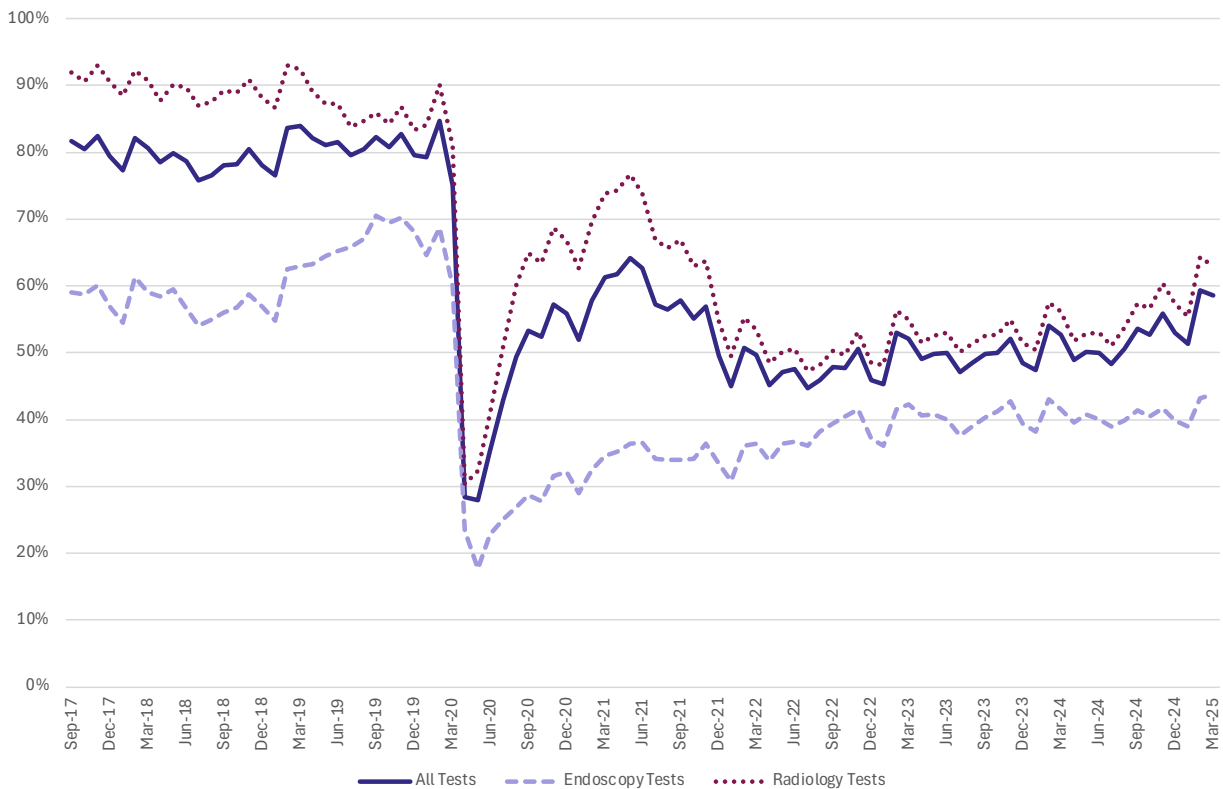
Access to Acute Hospital Services

A&E Departments

A&E departments have not met the 95% standard for patients to be admitted, transferred or discharged within four hours since August 2017. With the exception of the Covid-19 period, performance has steadily worsened. In the first half of 2025, just 69.8% of attendances were seen within four hours. This decline cannot be explained by rising demand. Attendances have remained broadly stable over the past decade at just under 1.6 million annually. What has changed is the length of waits. In 2014, only 0.6% of patients waited more than eight hours and 0.1% more than 12 hours. By 2019 those figures had risen to 1.3% and 0.3%, respectively, but by 2024, they were 11.2% and 5% (Figure 15) [39].

Use of A&E is highest among older adults, with 11,500 attendances per 100,000 people, almost double the rate of those aged 40–64. Children and young people are the next most frequent users, with around 9,000 attendances per 100,000. Referral patterns are also shifting. In 2018, 60% of attendances were self-referrals. By 2025, this had fallen slightly to 56%, reflecting increased triaging through NHS 24 and general practice (Figure 16). Older adults (75+) are least likely to self-refer, with only 31% doing so, while almost 7 in 10 attendances for children and young people come through self-referral. Understanding the drivers of this higher rate of self-referral could provide options to divert these patients to alternative care and more appropriate advice options.

There has also been a change in the patient mix. Between 2014/15 and 2023/24, A&E attendances increased among people with inpatient mental health needs and those with substance misuse, while attendances for people at the end of life declined [7].
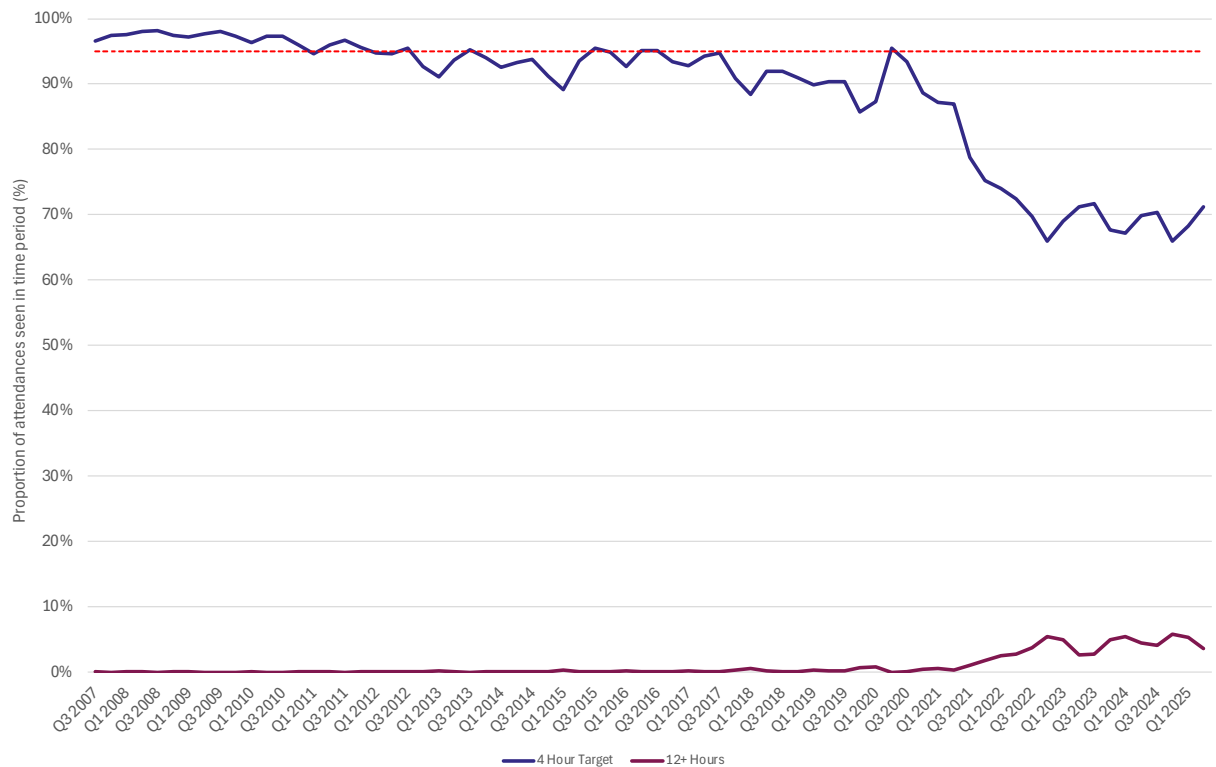
Another notable shift has been the reduction in admissions from A&E. Across all age groups, the proportion of attendances leading to hospital admission has fallen, with the rate among those aged 75+ dropping from 60% in 2018 to 56% in 2025 (Figure 17). This could reflect higher thresholds for admission, with only more complex cases admitted. Alternatively, it may signal that A&E departments are doing more to investigate, treat, and discharge patients without the need for admission. If so, this may also help explain why patients are waiting longer in A&E before a decision is reached but could also indicate that patients could be treated more appropriately elsewhere. Further work is needed to understand these dynamics and steps that could therefore be taken to drive down A&E waits for patients.

Figure 14. Diagnostic test waits - Six weeks or less

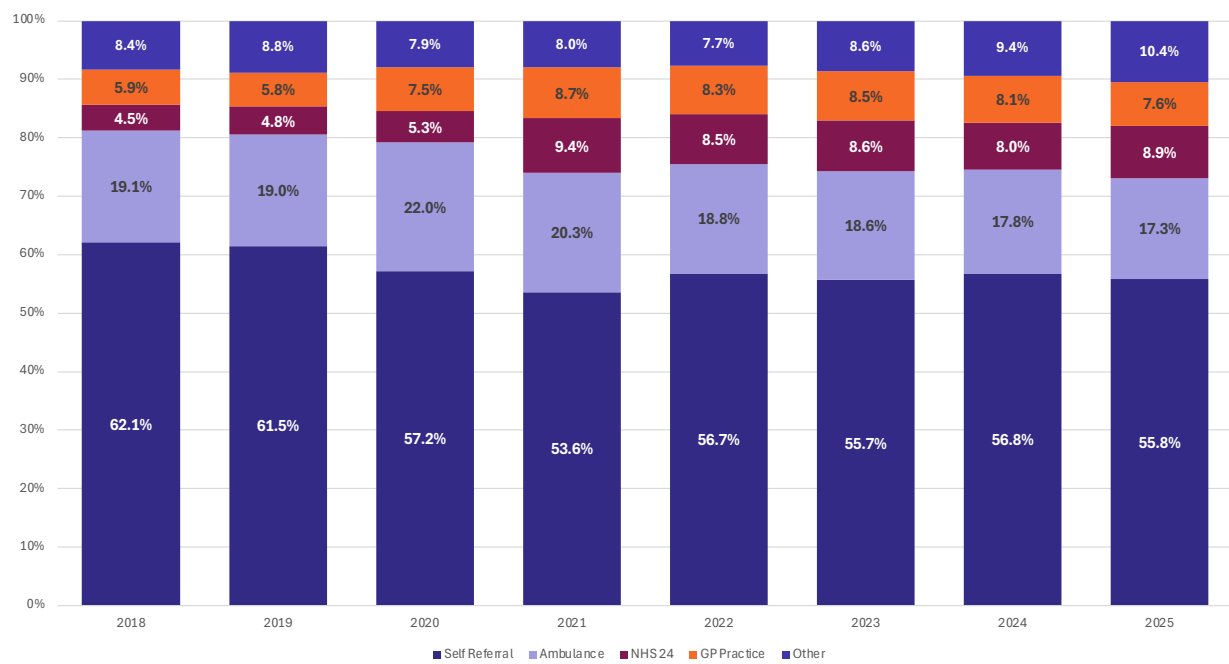*Source: Public Health Scotland, "NHS waiting times - diagnostics"*

Figure 15. A&E waiting times target

Source: Public Health Scotland, "Accident and Emergency"

Increased waiting times in A&E are reflected in triage performance. Triage waiting time refers to the length of time from a patient's arrival at hospital to being assessed by the duty nurse or clinician. In 2017/18, 1 in 5 people (20%) waited more than 15 minutes to be triaged. By 2024/25, this had risen to 27.5%. Much of this increase has been driven by longer waits: the proportion of patients waiting more than an hour to be triaged increased from 2.1% in 2017/18 to 5.7% in 2024/25 [40].

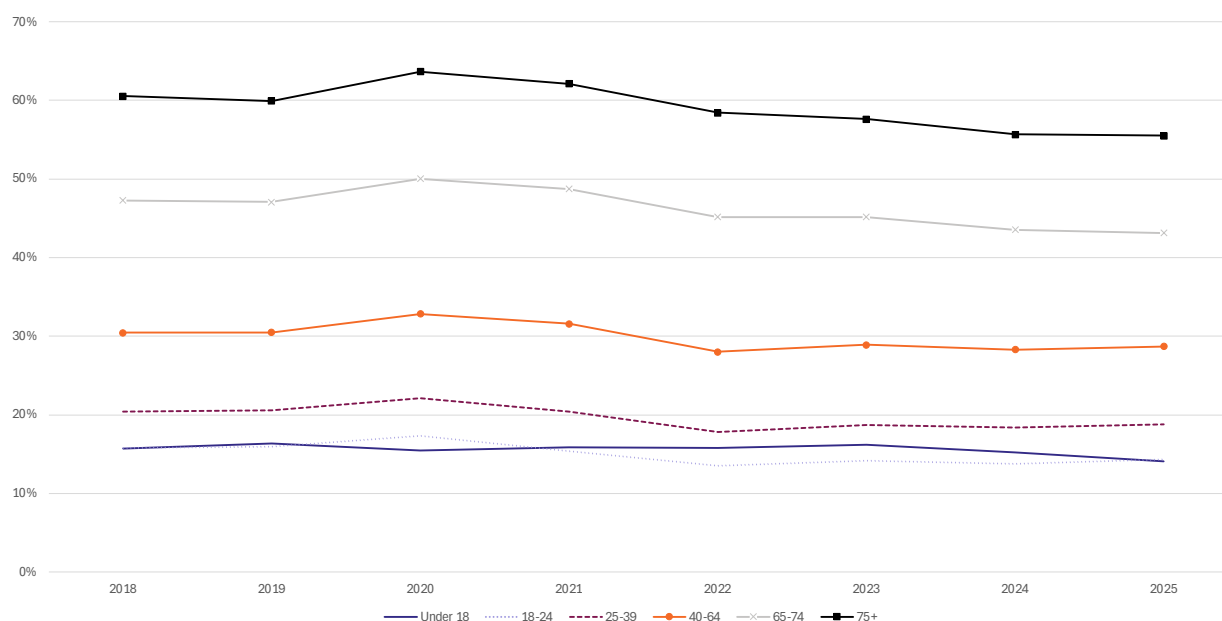*Figure 16. A&E attendances - Referral source*

Source: Public Health Scotland, "Accident and Emergency"

Inpatient Activity

Inpatient care in Scotland includes both elective and unplanned admissions. Elective admissions generally follow outpatient referrals and are subject to the Treatment Time Guarantee, which states that patients should receive treatment within 12 weeks of the decision to treat [41].

The elective treatment backlog continues to grow, with just under 160,000 people on the waiting list in June 2025. Numbers waiting over the past year have reached their highest on record. Referral volumes for elective treatment had been declining before the pandemic, falling by 16% between December 2013 and December 2019, and then dropped sharply during the pandemic. Since then, referrals have risen steadily but remain below pre-pandemic levels, reaching around 82% of the volume seen in the first 6 months of 2013 [31].

Figure 17. A&E attendances - Proportion admitted to hospital or transferred to other hospital

Source: Public Health Scotland, "Accident and Emergency"

Despite fewer referrals, performance against the Treatment Time Guarantee has steadily worsened. In 2013 almost all patients were treated within 12 weeks of the decision to treat, but by December 2019 less than 72% were meeting the target. During the pandemic, performance declined further, and since September 2022 the average has been around 57% (Figure 18). The number of patients waiting extreme lengths of time has also increased. In June 2025 around 15% of patients, equivalent to just under 9,700 people, had been waiting over a year for treatment. Of these, 1,800 had been waiting more than two years. The proportion of patients experiencing long waits varies by specialty, with 34% of orthopaedic patients, 21% of those in ear, nose and throat, 19% in gynaecology, and 16% in general surgery waiting over a year.

The combined number of elective inpatient (elective treatment with at least one overnight stay) and daycase (elective treatment conducted within one day) admissions reduced before the pandemic. Between 2014/15 and 2019/20 elective inpatient admissions fell by 25%, while daycase admissions rose slightly by 2.8%. Changes in patient pathways moved some treatments from inpatient to daycase, but even accounting for this there were 33,000 fewer elective treatments in 2019/20 compared with 2014/15. After the pandemic both elective inpatient and daycase admissions began to recover. By 2023/24, daycases had returned to around 95% of the number seen in 2019/20, while elective inpatient admissions were approximately 79% (Figure 19). The average length of stay for elective admissions decreased from 3.9 days in 2014/15 to 3.4 days in 2023/24, suggesting that longer stays are not driving the backlog (Figure 20).

Between 2014/15 and 2019/20, unplanned inpatient admissions increased by 7% (Figure 19). Over the same period, the total number of beds used for emergency patients fell by 1.4%. This was achieved through shorter lengths of stay, which allowed more admissions using the same resources. This productivity gain was reversed during the pandemic. By 2022/23, the average length of stay for emergency admissions had risen to 7.7 days, 1.1 days longer than in 2019/20 (Figure 20). In 2023/24 the average fell slightly to 7.25 days, close to the 2014/15 level of 7.2 days. Studies in England suggest that this increase was partly due to an ageing and ailing population, but a larger driver was the impact of Covid-19 [41]. As Covid-19 admissions continue to reduce, it should be possible for productivity to recover. As is discussed below, delivering productivity is a necessity for improving the performance of NHS services and delivering better outcomes for patients.

Rising emergency demand and longer hospital stays have likely reduced the number of beds available for elective treatment. The share of beds used by unplanned patients rose from 84% in 2014/15 to over 90% in 2023/24. Within specialties this shift was particularly marked (Figure 21), with beds used by emergency patients increasing in ear, nose and throat from 48% to 61%, in orthopaedics from 63% to 76%, with a peak of 84% in 2020/21, in gynaecology from 32% to 51%, and in general surgery from 72% to 74%. This illustrates the potential opportunity cost inherent in hospital capacity; each bed occupied by an emergency patient potentially reduces the ability to treat elective patients. Longer waits may also lead to patients requiring emergency care, further increasing pressure on the system.

Patterns of hospital use have also shifted across population segments. Between 2014/15 and 2023/24 unplanned bed days declined among frail patients and those at the end of life, whilst usage increased among patients with mental health conditions and substance misuse [42]. Some of this change is positive, for example reductions in frailty and end of life admissions may reflect greater care being delivered in the community. At the same time, the growth in mental health and substance misuse admissions highlights emerging pressures on inpatient services.
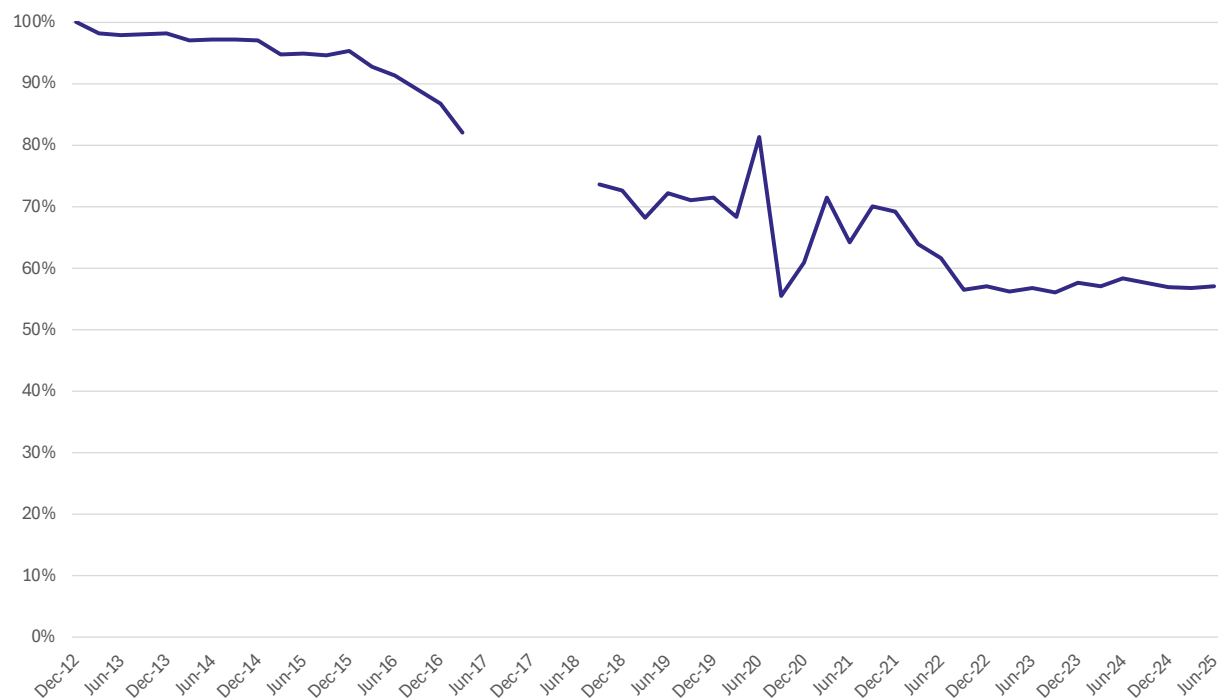
The age distribution of unplanned bed use has remained stable over the past decade. Around 70% of unplanned beds continue to be occupied by people aged over 65, and one in four by those over 85. This underscores the enduring impact of an ageing population on hospital capacity, even as the drivers of admission evolve [31].

***

Demand for NHS services has never been higher, yet access has deteriorated across almost every stage of the patient journey. New routes such as Pharmacy First have expanded options for unscheduled care, yet waits remain longer in nearly all services, suggesting that this expansion has been absorbed by increased demand, as opposed to relieving pressure elsewhere. This deterioration in access for patients was evident before the Covid-19 pandemic, with lengthening waits for elective procedures, outpatient appointments, CAMHS, ambulance responses and A&E

all before March 2020. The marked growth in waits since then indicates that the impact of the pandemic has been to accelerate this trend.
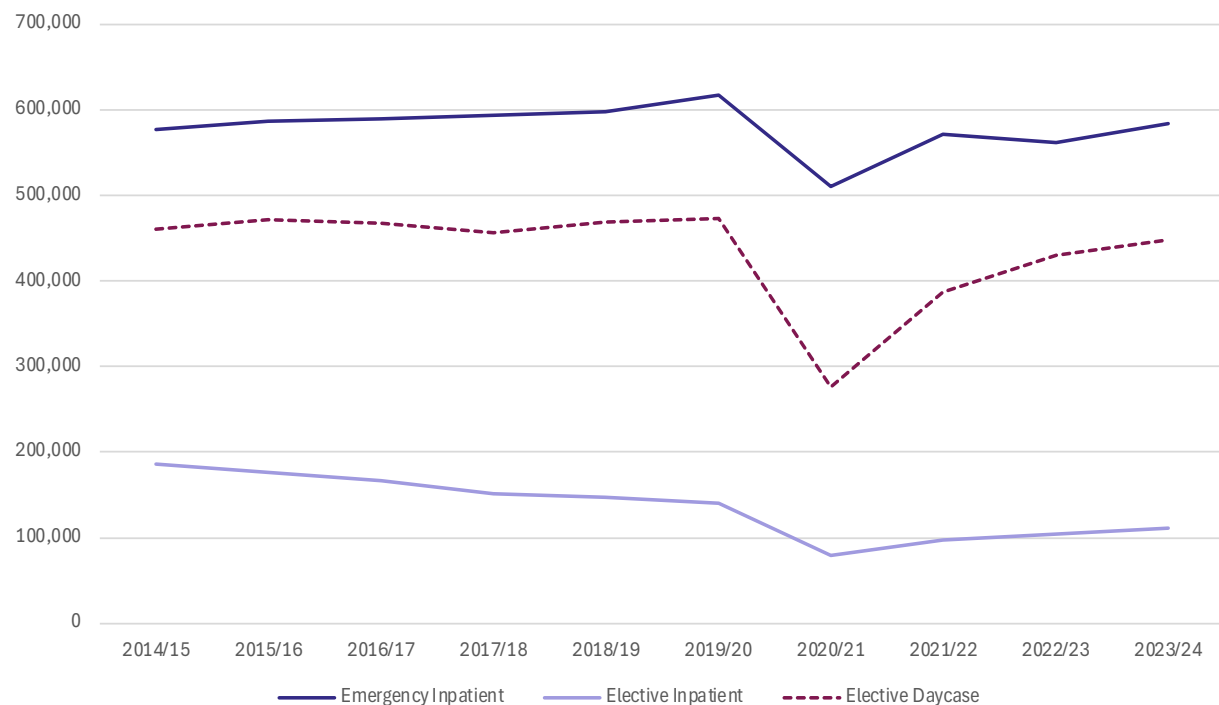
Challenges with access are usually a warning sign of deeper issues within the wider health and care network. The pressure that unmet demand places on the workforce and facilities can also have implications, in turn, for the performance and quality of care that services are able to provide. Turning this around will therefore require action across the whole system.

Figure 18. Proportion of patients seen in elective treatment - Within 12 weeks of referral
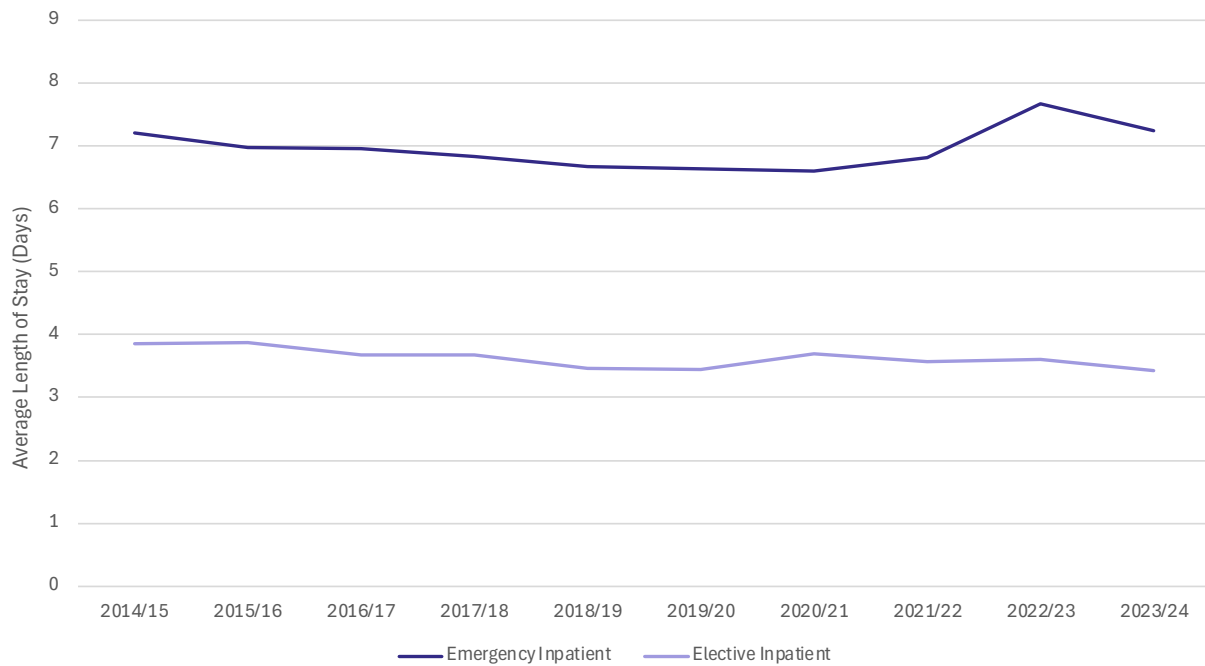

Source: Public Health Scotland, "NHS waiting times - stage of treatment"

Figure 19. Number of hospital admissions
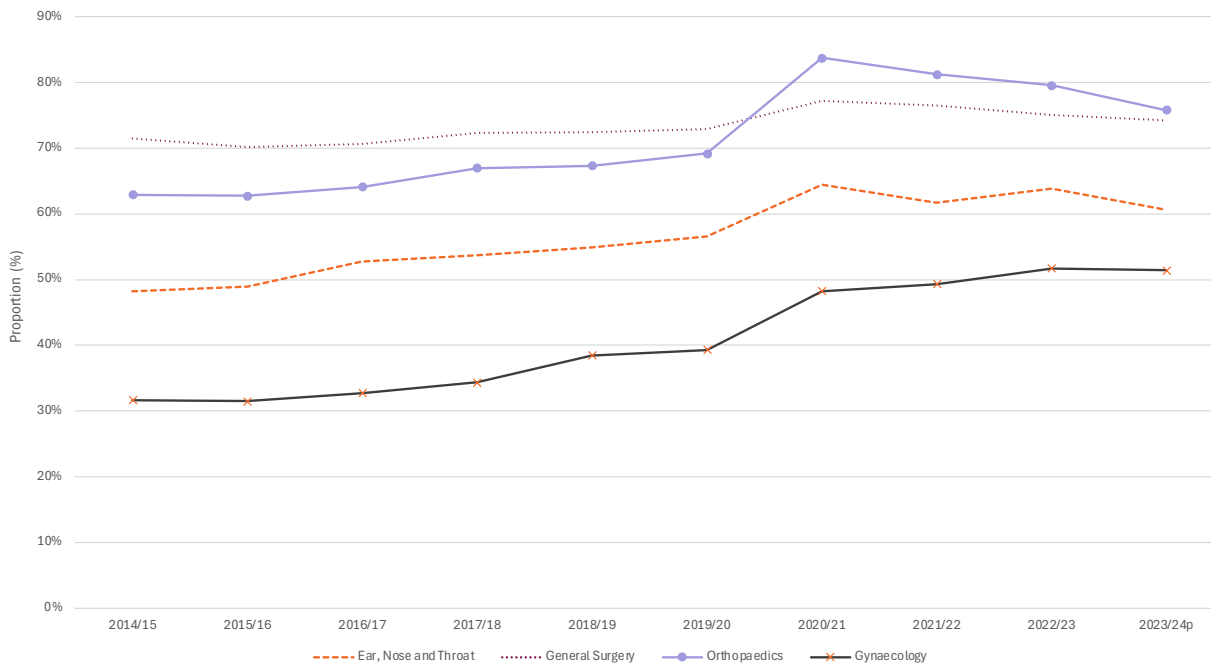

Source: Public Health Scotland, "Acute hospital activity and NHS beds information"

Figure 20. Average length of stay in hospital

 Source: Public Health Scotland, "Acute hospital activity and NHS beds information"

Figure 21. Proportion of hospital beds occupied by unplanned patients

Source: Public Health Scotland, "Acute hospital activity and NHS beds information"

Chapter 3.
Quality and Performance of the NHS

Understanding how patients enter the system is only part of the story. It is equally important to examine what happens once care is delivered. This chapter examines whether care is effective, safe, and trusted — how well the NHS converts treatment into recovery, protects patients from avoidable harm, and maintains public confidence.
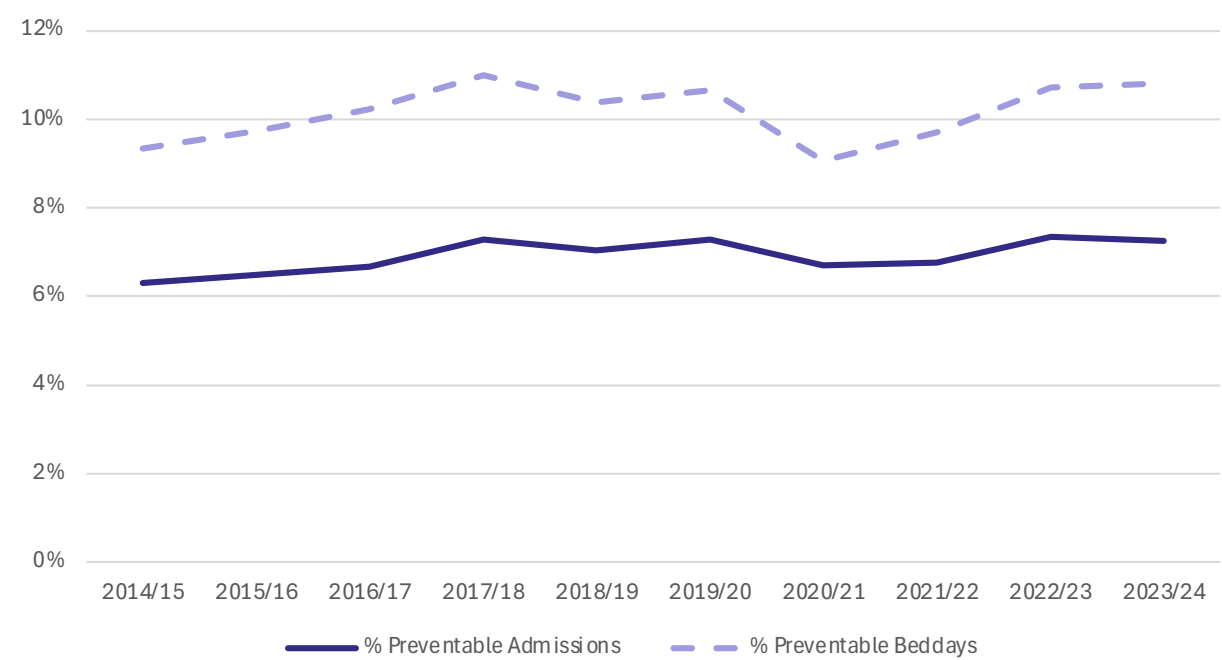
Effectiveness of Care

A high-performing system ensures that the care provided achieves its intended results and supports recovery and wellbeing. This section explores how effectively services meet the needs of patients and the system's ability to provide timely, coordinated, and appropriate treatment.

Potentially Preventable Admissions

Potentially preventable admissions — that is to say cases that could have been avoided with timely community care — are a sensitive barometer of system effectiveness. Over the past decade, potentially preventable admissions have risen from 6.3% of all admissions in 2014/15 to 7.3% in 2023/24. The share of hospital beds they occupy has also grown, from 9.4% to 10.8% over the same period (Figure 22) [42]. This shift is equivalent to an additional 91,000 beds being used in 2023/24 for patients whose admission might have been avoided. These admissions also have longer average lengths of stay than non-preventable admissions. Preventing them would therefore release more hospital capacity than reducing admissions more generally.
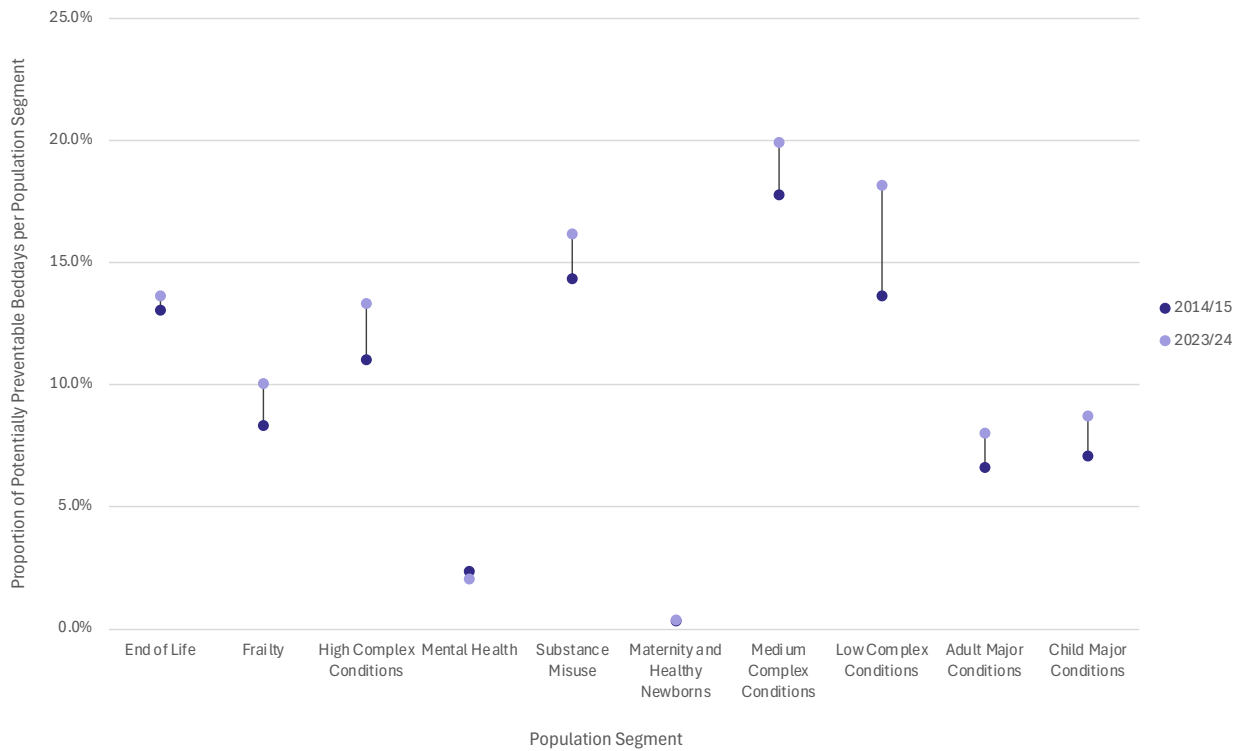
Preventable admissions are most common among patients with long term conditions, where poor coordination of care is a known risk. Individuals in the medium complex conditions cohort — including people living with coronary heart disease, Parkinson's disease, multiple sclerosis or chronic obstructive pulmonary disease (COPD) — and the low complex conditions cohort — including people living with asthma, arthritis, epilepsy or diabetes — have the greatest likelihood of potentially preventable admissions. In the medium complexity group, around 20% of bed use is attributable to preventable admissions, more than double the average. Most population groups saw increases over the past decade (Figure 23), suggesting that coordination of community care may have become less effective.

Figure 22. Potentially preventable admissions - Percentage of admissions and beddays

Source: Public Health Scotland Information Request

Figure 23. Proportion of potentially preventable beddays per population, 2014/15 vs 2023/24

Source: Public Health Scotland Information Request

Repeat Admissions and Attendances to Hospital

Monitoring repeat hospital use for unplanned care provides important insights into the quality and continuity of care. High rates of readmission can indicate problems with discharge planning, gaps in follow-up, or limited support in the community. Similarly, multiple A&E attendances or repeated emergency admissions may reflect unmet needs, poor management of long-term conditions, or a lack of effective alternatives to hospital care.

Unplanned readmissions have remained stubbornly high at around one in four, with little improvement in a decade. Among children and young people aged 0 to 19, the rate rose from 17% in 2014/15 to over 24% in 2023/24. For adults aged 20 to 74 and those aged 75 and older, readmission rates have remained relatively stable, typically close to 25% (Figure 24) [43].

From July 2024 to June 2025, around 24% of individuals attending A&E had multiple attendances within the 12-month period, with 8% having three or more. Children under 18 and adults over 75 were the most likely to re-attend [39].

Around one in four patients experienced multiple emergency admissions in 2023/24, with 16% having two admissions and 9% having three or more. This distribution has been consistent across the past decade. More than half (51%) of all multiple admissions involve adults aged over 65. There has been a modest improvement within this group, mainly due to a reduction in the proportion experiencing three or more admissions. In 2014/15, over 12% of older adults with an unplanned admission experienced three or more admissions within the year, falling slightly to 11% by 2023/24 [31].

Reducing repeat admissions is important not only for system efficiency but also for patient wellbeing. Fewer emergency admissions help people remain in the community, avoid exposure to hospital-acquired infections, and reduce the risk of complications such as falls or delirium that can be particularly harmful for older adults [44].

Delayed Discharge

Delayed discharges are a well-recognised marker of system inefficiency and poor patient experience. They occur when patients are medically fit to leave hospital but cannot be discharged, often because of bottlenecks in social care, community provision, or hospital discharge processes. For patients and their families, this can be distressing and disorientating, while for the NHS it ties up beds that could otherwise be used for new admissions [45].

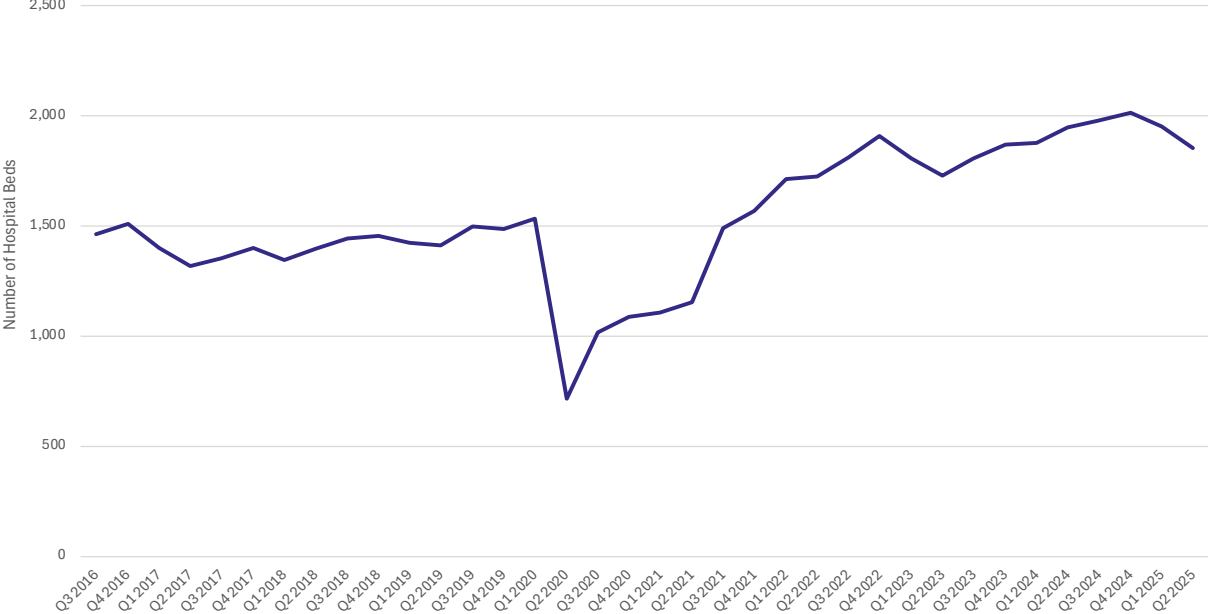The number of occupied beds due to delay has risen from 1,400 in 2019 to about 2,000 in late 2024, representing one in nine (10.8%) acute beds in 2023/24 (Figure 25) [46].

Figure 24. Proportion of emergency admissions with a readmission - 28 days of a previous discharge

Source: Public Health Scotland FOI Data

Figure 25. Number of beds occupied by delayed discharges

Source: Public Health Scotland, "Delayed Discharges"

This growth has not been driven by more patients experiencing a delay. Before the pandemic, the number of discharges that followed a delay rose gradually from just under 5,000 per month in 2017 to over 6,000 at the start of 2020 (Figure 26). Since then, the number has not exceeded 5,000 per month, even during the winter months when pressures are typically greatest. Instead, the increase reflects longer waits for those who are delayed. Prior to the pandemic, the median length of delay was around 15 days. In 2024/25 it averaged closer to 20 days.

The destination of discharge has remained relatively stable, with around 60% of patients eventually returning home and 40% discharged into a placement such as a care home. This consistency suggests that changes in destination are not driving the longer delays.
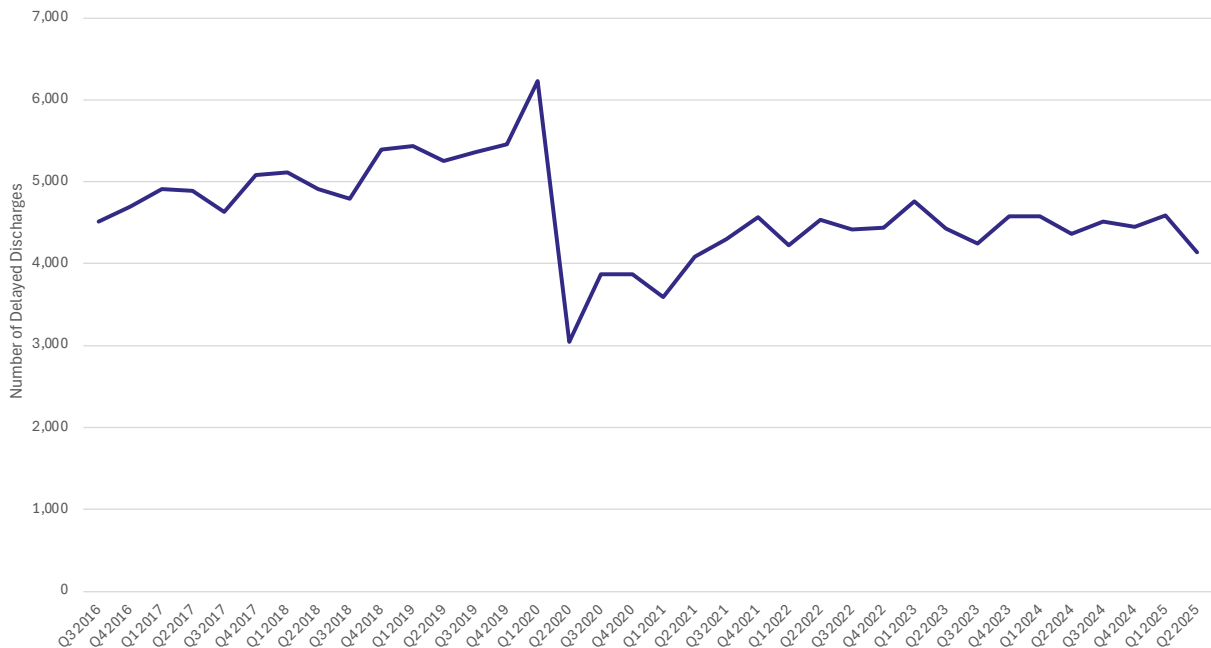
The persistence of delayed discharges suggests structural problems in system flow. These include both bureaucratic barriers to timely discharge within hospitals and capacity constraints in social care and community services. In practice, the causes are likely to be a combination of the two.

The cumulative impact of preventable admissions, readmissions, and delays is to keep hospitals operating near capacity — a known risk factor for safety incidents.

Safety

Patients and the public rightly expect health care to be safe and to protect them from harm. This section examines where risks emerge, the consequences of failures, and the importance of timely intervention in maintaining safety and trust.

Figure 26. Number of admissions resulting in a delayed discharge

Source: Public Health Scotland, "Delayed Discharges"

Clinical Negligence

Clinical negligence claims offer an important perspective on patient safety, highlighting instances where avoidable harm has occurred. The number of claims peaked in 2014/15 and has since stabilised, averaging around 500 claims per year [47]. Payments for clinical claims over the past decade have averaged approximately £50 million annually, although there is considerable variation in value, reflecting that higher costs are not necessarily linked to a greater number of claims. For example, the spike in 2021/22 was driven by a small number of claims exceeding £1 million each. Obstetrics and emergency medicine account for the largest share, reflecting the complexity and consequences of errors in these fields [48].

Hospital Acquired Infections

Analysis of healthcare-associated infections, including Clostridium difficile, Escherichia coli, and Staphylococcus aureus bacteraemia, shows that rates in healthcare settings have remained broadly stable over the past eight years. While there have been minor fluctuations, the overall picture suggests that infection control measures have largely maintained previous gains [49]. Community-acquired infections follow a similar pattern, with small rises and falls over the same period. The persistence of these infections underscores the ongoing challenge of reducing risk to patients and the impact on healthcare services, highlighting the importance of continued vigilance in infection prevention and control.

Scottish Patient Safety Programme

Established in 2008 the Scottish Patient Safety Programme (SPSP) was nation-wide quality improvement programme. Starting in acute hospitals it worked with teams to test evidence-based improvements in care, measuring outcomes for patients, and rolling out guidance and best practice across the whole healthcare system.

Prior to the pandemic, the 2016 Acute Adult Programme delivered a number of notable achievements, including a 16.5% reduction in Hospital Standardised Mortality Ratio compared to the 2007 baseline, and 21% reduction in 30-day sepsis mortality [50].

Currently there are a number of SPSP programmes running, including in perinatal care, paediatrics, mental health, and primary care. The most recent Acute Adult Programme for 2021-2024 delivered a nationwide 9% reduction in the number of falls but more of a mixed picture in supporting deteriorating patients. By the end of the programme, three hospitals in two NHS boards demonstrated a reduction in cardiac arrests, while increases were reported in three NHS boards [51]. The results underline the importance of reliable data collection for testing and driving improvements — something which can be increasingly challenging when services are under pressure.

Avoidable Mortality

Avoidable mortality refers to deaths from causes that should not occur in the presence of timely and effective prevention or treatment. These are typically divided into two groups. Preventable mortality captures deaths that could have been avoided through public health interventions such as smoking cessation, vaccination, or harm-reduction policies. Treatable mortality covers deaths that could have been avoided through effective healthcare, such as early detection, treatment, and secondary prevention.

Scotland has consistently had the highest avoidable mortality rate in Great Britain for individuals aged below 75. In 2023, mortality rates in Scotland exceeded those in England and Wales across all major avoidable causes of death, a pattern that has persisted for most major conditions since 2001 [52].
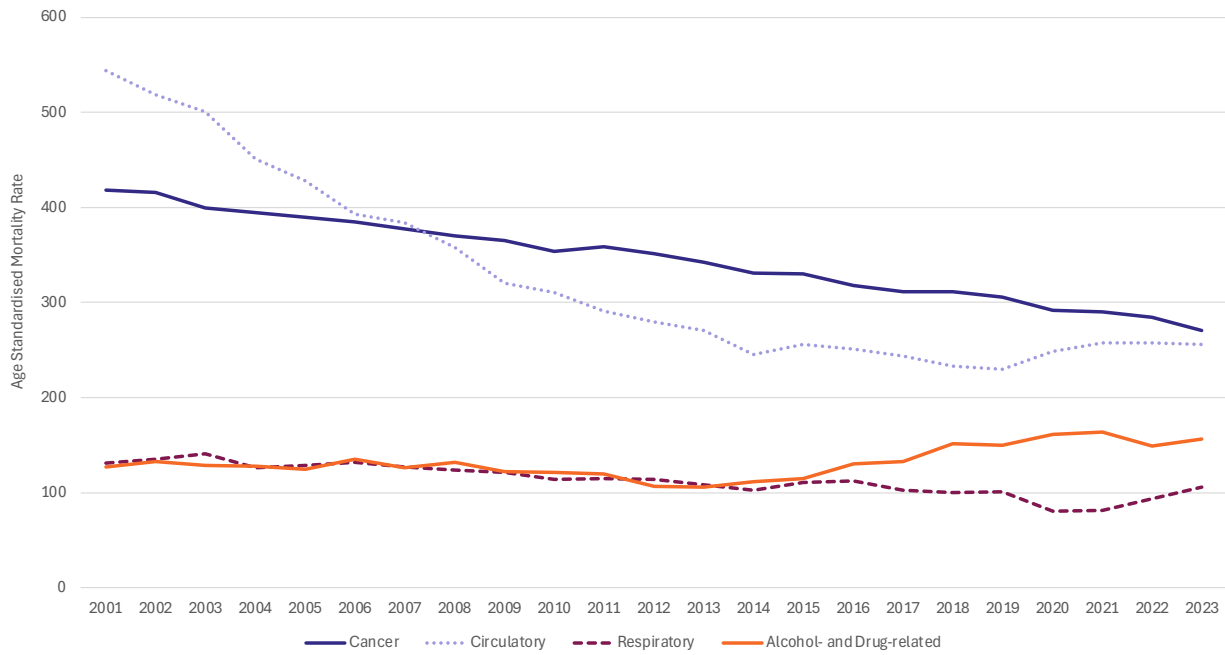
Cancer

Cancer has been the leading cause of avoidable mortality among people under 75 since 2008. Once adjusted for age, the cancer mortality rate for under-75s fell by an average of 1.9% per year between 2003 and 2023 (Figure 27). At the same time, cancer incidence rose, with crude rates increasing by 0.9% per year and age-standardised rates by 0.2% per year between 2002 and 2022 [53]. This combination suggests survival has improved. Early diagnosis is central to improving outcomes, yet screening uptake is mixed. Bowel and breast cancer screening uptake has improved in recent years, with bowel screening meeting the target for both men and women, but cervical screening has declined since the pandemic [54] [55] [56]. Across all three programmes, uptake is lower in the most deprived communities, with no target met in the most deprived quintile.

Cancer waiting times remain a major concern. The 62-day standard, which requires 95% of patients to begin treatment within 62 days of urgent referral, has not been achieved nationally since 2014 (Figure 28). In 2025, performance was below 70%, with breast, colorectal, and lung cancers all falling short. The 31-day standard, which measures the time from 'decision to treat' to first treatment, performs slightly better, though still below the 95% target overall. As of the most recent quarter, the national average was 94%, with breast, colorectal, and lung cancer all above target [57].

Cardiovascular Health

Cardiovascular disease is the second largest cause of avoidable mortality for the under-75 population. Substantial progress was made in reducing deaths in the early 2000s, but improvement has stalled since around 2014 (Figure 27). Inequalities remain stark. In 2023, people under 75 living in the most deprived areas were almost four times as likely to die from heart disease as those in the least deprived areas, up from three times in 2003.

Figure 27. Avoidable mortality by major causes

Source: National Records of Scotland, "Avoidable Mortality, 2023"

Figure 28. Cancer waiting times - Proportion meeting 62-day standard

Source: Public Health Scotland, Cancer Waiting Times

Respiratory

Respiratory conditions are the third leading cause of avoidable mortality. Between 2003 and 2023, rates declined steadily, falling by an average of 1.4% each year (Figure 27). Yet the burden is not shared equally. In 2023, people under 75 living in the most deprived areas were almost nine times more likely to die from respiratory disease than those in the least deprived areas, up from less than five times in 2003. Higher smoking prevalence in deprived communities and poor housing conditions, including dampness — experienced three times more often by private renters than by owner-occupiers — continue to drive these inequalities.

Drug and Alcohol

Since 2015, alcohol-related and drug-related mortality combined has been the third leading cause of avoidable deaths among those under 75, rising by around 4% each year (Figure 27).

A key driver of this increase has been the sharp rise in drug-related deaths. After adjusting for age, the rate of drug misuse deaths in 2024 was 3.6 times higher than in 2000 [58]. Scotland's drug-related mortality rate is far above that of any other European country, leading it to be labelled the "drug death capital of Europe" [59].

Along with alcohol-related deaths and suicide, drug deaths are often described as part of the wider category of 'Deaths of Despair'. This term captures deaths linked to feelings of hopelessness and a lack of opportunity, reflecting wider social and economic determinants of health [60]. The share of all deaths in Scotland attributed to deaths of despair has increased from 3% in 1996 to more than 5% in 2023 (Figure 29).

Alcohol-related mortality fell in the early 2000s once adjusted for age, but that progress stalled in the 2010s and has since begun to reverse [61]. Suicide rates have fluctuated over time but show a gradual downward trend [62], while drug deaths have risen sharply, particularly after 2013 (Figure 30).

Deaths of Despair show a steep and persistent deprivation gradient. In 2023, alcohol-related deaths were four times higher in the most deprived quintile than in the least deprived, suicides were over eight times higher, and drug deaths were 14 times higher. While deprivation gaps in alcohol-related deaths and suicides have narrowed slightly, the inequality in drug-related deaths has widened, with those in the most deprived communities increasingly bearing the greatest burden.

The link between Deaths of Despair and wider inequalities is also evident in the figures for people experiencing homelessness. In 2023, an estimated 242 people with no fixed abode died while homeless, 48% more than when these statistics were first reported in 2017 [63].

Deaths of Despair carry deep consequences not only for the individuals lost but also for families, communities, and wider society. Their persistence, and in some cases rapid escalation, underline the urgency of coordinated public health, social, and community responses.

Patient Experience

The perspective of those who use services offers vital insight into how the system functions in practice. This section considers how patients view their interactions with providers, how concerns are raised, and the implications of experience for public confidence and future use of services.

Patient Satisfaction

Anecdotally, many people feel that the level of care provided by the NHS has declined in recent years. This has also been borne out in empirical data. Population surveys suggest that overall, three in five people were satisfied with the NHS in the years before the pandemic. Post-pandemic data, though limited, shows a sharp drop to roughly one in five respondents. Similarly, the proportion of people who believed the standard of healthcare had improved has fallen dramatically. In the early 2000s, about one in 5 respondents reported improvements; this fell to one in 10 in the years leading up to the pandemic, and more recently only around one in 20 believe the health system's standard has increased [64].
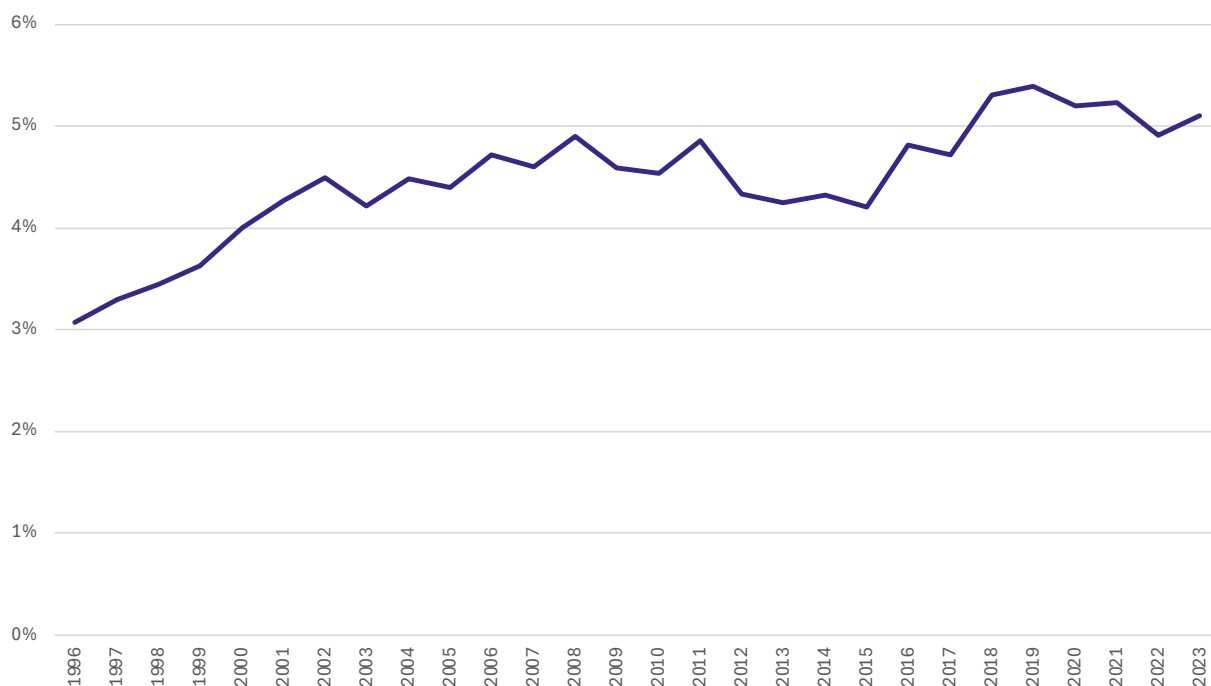
Private Provision of Healthcare

Rising waits for NHS care are prompting an increasing number of Scots to seek private treatment. Since 2019/20, admissions to hospital through private healthcare have risen by 55%, mostly for elective orthopaedics and ophthalmology [65]. Hip and knee replacements illustrate this shift. Pre-pandemic, around 10% of hip replacements were privately funded, rising to 25% by 2024 (Figure 31). Knee replacements increased from under 10% to over 21% (Figure 32) [66]. This trend risks entrenching a two-tier system where access depends on ability to pay.
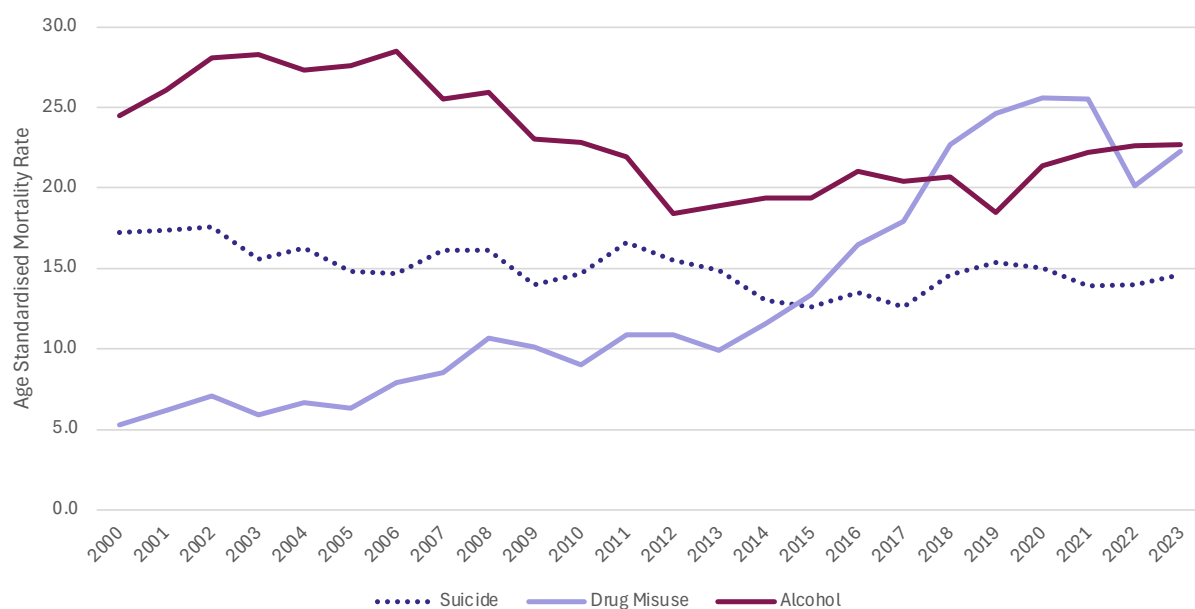
Complaints

The number of formal complaints about NHS services increased by 7% between 2017/18 and 2023/24. Complaints peaked in 2022/23 at just over 35,000, driven primarily by a rise in GP-related complaints, while complaints about acute NHS services remained broadly steady. The rate at which complaints were partially or fully upheld fell during the pandemic but has since returned to pre-pandemic levels of around 55% [67]. This trend highlights growing concerns from the public about access and primary care experiences, and reinforces the importance of effective complaint handling as a tool for improving services and maintaining public trust.

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Figure 29. Individuals dying from Deaths of Despair as proportion of total deaths

Source: National Records of Scotland, "Drug-related deaths in Scotland, 2024", "Alcohol-specific deaths 2024", "Probable suicides 2023"

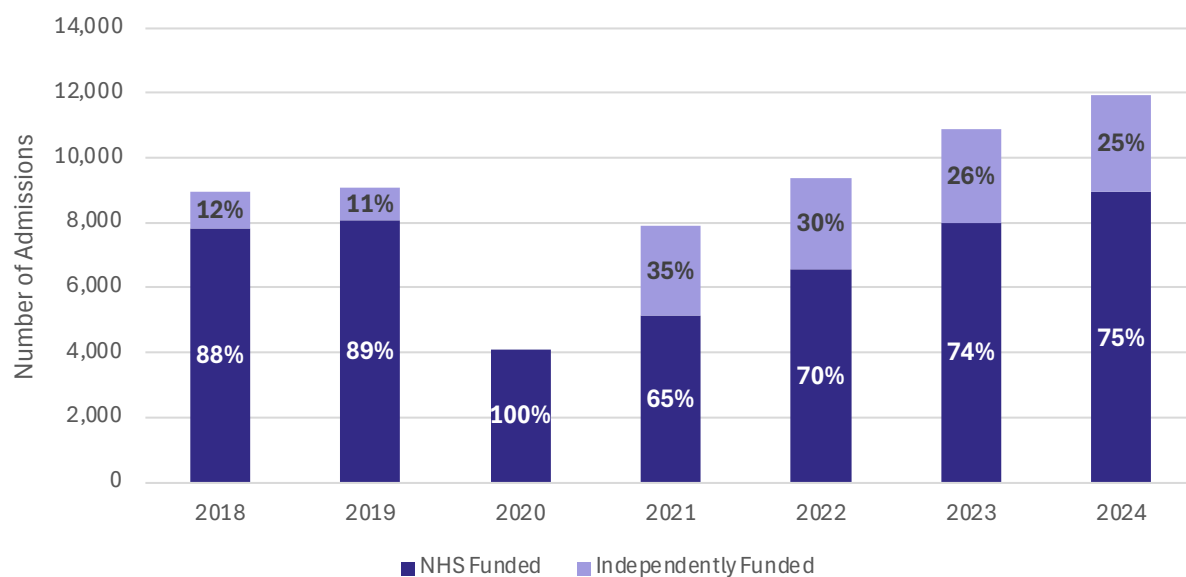*Figure 30. Components of Death of Despair - age standardised mortality rate*

Source: National Records of Scotland, "Drug-related deaths in Scotland, 2024", "Alcohol-specific deaths 2024", "Probable suicides 2023"

Ultimately the NHS is still trusted to act and is where Scots first turn when they face ill health. Taken together though, falling satisfaction, rising private use, and persistent complaints reveal a health system under strain. Rebuilding confidence will depend on visible improvements in access, communication, and outcomes.

Overall, the NHS in Scotland continues to deliver safe and effective care for most patients, although in many areas, avoidable pressures remain. Preventable admissions, delayed discharges, and widening inequalities point to a system struggling to convert effort into better outcomes. Reversing this trend will require coordinated action across health and social care, focussing not solely on hospital and emergency care but instead on health promotion, earlier interventions, and renewed prioritisation of prevention.

Figure 31. Hip arthroplasty

Source: Public Health Scotland, "Scottish Arthroplasty Project"

Figure 32. Knee arthroplasty

Source: Public Health Scotland, "Scottish Arthroplasty Project"

Chapter 4.
Health Prevention, Promotion and Inequalities

This chapter examines how well NHS Scotland protects and promotes the health of its population, and whether the benefits of technological progress and medical research are shared equally. It considers infectious disease control in the wake of the pandemic, the promotion of healthier behaviours, and the persistent inequalities that shape people's experiences of health and care.

Health Protection

The Covid-19 pandemic underlined that infectious disease remains a major challenge for all health systems. Yet, in its aftermath, falling vaccination rates now risk the resurgence of illnesses once thought to be under control. Covid-19 itself continues to place pressure on services — in the first half of 2025, more than 1,200 people were admitted to hospital in Scotland with the virus [68] — but the greater long-term risk lies in the re-emergence of preventable diseases as vaccine confidence wanes.
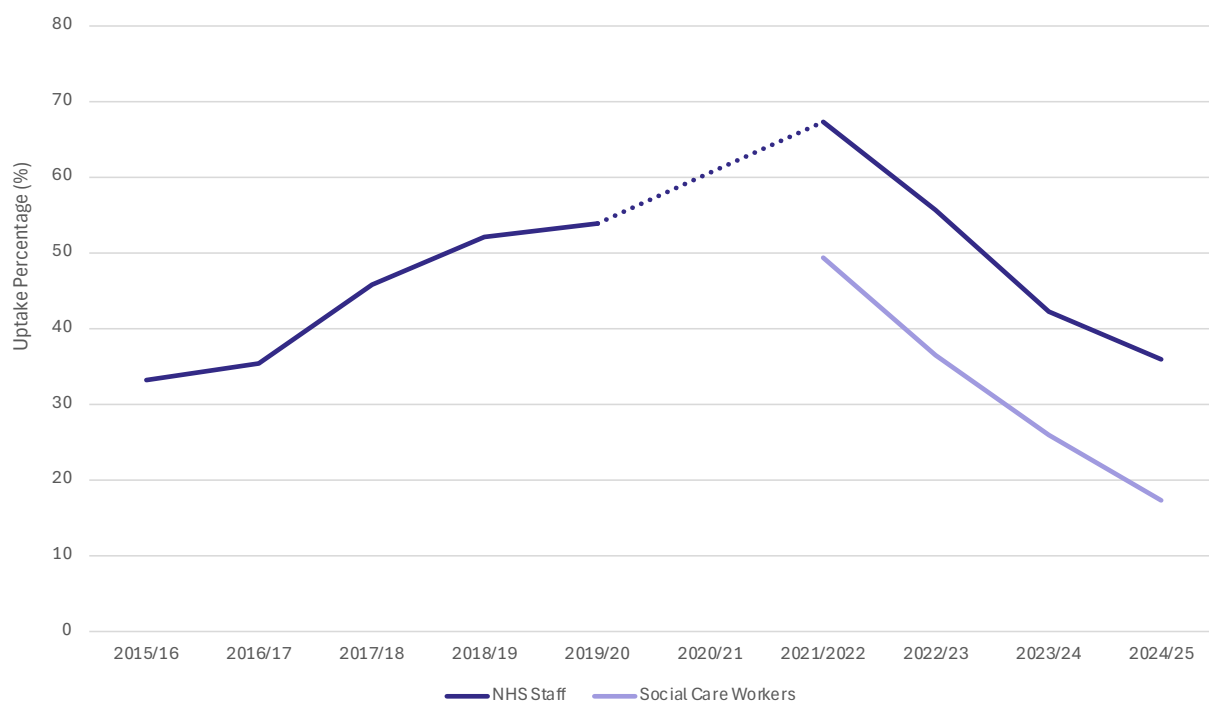
Childhood Vaccines

Vaccination during childhood provides protection against some of the most serious infectious diseases. Yet uptake has been declining. In 2025 coverage of the first dose of the MMR vaccine at 24 months had fallen to below 93%, missing the World Health Organization target of 95% required for population-level protection. Similar declining trends are seen across other key vaccines, including the Six-in-One and MenB at 12 months [69]. Uptake is lowest in deprived areas where children are six percentage points less likely to be vaccinated with MMR1 at 24 months than those in the least deprived — a gap that threatens to widen existing health inequalities.

Flu Vaccination

Flu vaccination helps prevent severe illness, hospitalisation, and winter pressures on the NHS, yet coverage has weakened. Among older adults, uptake fell in the years before the pandemic but surged to over 90% in 2021/22 as Covid-19 vaccine roll-out boosted participation. By winter 2024/25, however, uptake had returned to pre-pandemic levels of around 74% (Figure 34) [70].

Figure 33. Flu vaccination rates for health employees

Source: Public Health Scotland FOI Data

Figure 34. Flu vaccination rates for population groups

Source: Public Health Scotland FOI Data

For at-risk adults under 65, uptake has been persistently low. Fewer than half received the vaccine from 2015/16 onwards, rising slightly during the pandemic but falling back to just 35% in 2024/25 (Figure 34).

Among health and social care workers, coverage has dropped dramatically. In 2021/22, 68% of NHS staff and 49% of social care staff were vaccinated. By 2024/25, uptake among social care staff had collapsed to just 17% (Figure 33). This poses clear risks, as staff working closely with vulnerable people can inadvertently spread infection.

The downward trend in flu vaccination across priority groups is concerning. Beyond individual protection, vaccination reduces hospital admissions, shortens illness duration, and helps keep the system resilient during winter peaks in demand. Rebuilding confidence in vaccination requires sustained communication and easy access, not just campaign surges at times of emergencies.

Health Promotion

Health outcomes can be improved not only by treating illness but by reducing the risks that cause it in the first place. Scotland has introduced some bold measures in recent years, with clear evidence of impact, though progress has been uneven across different areas of public health.

Prevention is more than immunisation. Scotland has pioneered bold public health interventions, but progress has been uneven — with notable success on tobacco and alcohol, slower progress on obesity, and continuing crisis in drug harms.

Alcohol

Scotland's introduction of minimum unit pricing (MUP) in 2018 is one of the most significant public health interventions of recent years. Across the first 32 months of implementation, there was a 13% reduction in deaths wholly attributable to alcohol consumption compared with the level expected without the policy, equivalent to around 156 deaths avoided each year. Hospital admissions for alcohol-related conditions also fell by 4%, or 411 admissions per year [71]. However, alcohol-related deaths have risen again in recent years, highlighting that MUP alone cannot offset deep-rooted social and economic drivers of harm, and that therefore further action is required.

Smoking

Smoking prevalence has fallen steadily, supported by successive waves of legislation, taxation, and behaviour change campaigns. These reductions have contributed directly to improvements in cardiovascular health and cancer outcomes [72]. With fewer smokers, the use of cessation services has naturally declined.

Drugs

Scotland has long had persistently high levels of substance misuse and drug-related deaths. Funding cuts imposed on alcohol and drug services following 2015/16 [73] limited the availability of recovery services and a rise in drug-related deaths followed. Deaths reached a peak in 2020 with a total of 1,339 lives lost and an age standardised mortality rate of 25.6 per 100,000 [74]. In 2019 the Scottish Government launched a Drugs Deaths Taskforce, but the slow progress made was widely criticised. In 2021 the First Minister launched the National Mission on Drugs, with £250m of funding to support recovery services, residential rehabilitation, and harm reduction interventions. There were initial delays or issues with the implementation of some commitments, including increases to rehab beds, drug testing facilities and the roll out new Medication Assisted Treatment standards, but progress has been made [73]. Deaths have started to reduce from the 2020 peak, with a 2024 mortality rate per 100,000 of 19.1, albeit this remains substantially higher than the 13.4 rate in 2015 [74].

As part of efforts to address persistently high drug-related mortality, Scotland has begun piloting safer drug consumption facilities. The aim is to reduce health and social harms, including blood-borne infections and overdose deaths by providing supervised spaces for use [75]. Evaluations are expected later this decade. Although international evidence suggests they can play an important role as part of wider harm-reduction strategies [76] [77], there may be a number of unintended consequences that also require consideration [78].

Obesity

By contrast, Scotland's response to obesity has lacked similar ambition. In 2023 almost two-thirds (66%) of adults in Scotland were found to be overweight or obese, up four percentage points in 10 years, and consequently there are growing numbers living with diabetes. Adults in the most deprived areas are also 44% more likely to be obese. Physical activity levels have improved modestly, but stronger regulatory measures on food and drink, such as restrictions on marketing, pricing, or reformulation have been slow to materialise.

The UK Government is funding a study led by the University of Glasgow into the use of weight loss medications, targeted in the most deprived areas [79]. This presents an opportunity to assess the effectiveness of such medications as a route to reducing the scale of obesity in Scotland.

Inequalities in Care

Despite Scotland's universal healthcare system, care is not equally accessible or effective. Geography, deprivation, and social circumstances continue to shape how, and how well, people receive care. Scotland continues to demonstrate the "inverse care law" that those with the greatest health needs often face the greatest barriers to receiving timely and effective care [80].

Inequalities in General Practice

General practice is the backbone of the health system, yet provision does not always reflect need. People living in the most deprived areas are more likely to experience multiple long-term conditions, requiring greater input from primary care [81]. However, practices in these areas receive roughly the same funding per patient as those in the least deprived communities, despite the heavier workload and patient complexity [77]. The introduction of the Deep End network sought to address this gap by targeting resources towards practices in highly deprived areas, but stakeholders report that it has not been sufficient to compensate for the scale of additional demand [77].

Scotland also faces unique challenges in rural primary care. With 98% of its land mass classified as rural but home to just 17% of the population, Scotland's geography creates distinct pressures [82]. In remote areas, GPs often take on a wider range of responsibilities than their urban counterparts. There are almost twice as many GPs per head of population in rural areas — one per 515 people in 2023, compared with one per 1,100 in urban areas (Figure 35) [83]. While this looks positive on paper, it does not always translate to easier access for patients, many of whom still face long travel times to reach care.

Inequalities in Hospital Care

Hospital use reflects the deep divide between more and less affluent communities. People in deprived areas are more likely to attend A&E and to be admitted to hospital, whether for elective or emergency care. Over the past decade, these inequalities have narrowed slightly, but they remain substantial.

In 2014/15, people from the most deprived quintile were 1.7 times more likely to attend A&E than those from the least deprived. By 2023/24, the gap had only narrowed to 1.6 times more likely. For hospital admissions, the difference fell from 1.4 to 1.3 over the same period (Figure 36) [84]. These figures are not adjusted for age, so part of the narrowing may simply reflect an ageing population in more affluent areas rather than real improvements for deprived communities.

The picture is similar for delayed discharges and potentially preventable admissions, both of which signal weaknesses in the broader system. In 2016/17, people in deprived areas were 1.6 times more likely to experience a delayed discharge, falling modestly to 1.4 by 2023/24. For potentially preventable admissions, the ratio was 2.2 in 2014/15 and remains high at 2.1, highlighting the ongoing challenge of inadequate primary and community care in deprived communities.

Geography adds another layer of inequality. Urban residents have historically been more likely than rural residents to attend A&E or face delays in discharge. In 2014/15, people from urban areas were 1.9 times as likely to attend A&E than those from rural areas, though by 2023/24 this gap had fallen to 1.4 times (Figure 37). For delayed discharges, urban residents were 1.7 times more likely to

experience a delay in 2016/17, but the difference narrowed to 1.2 times by 2023/24. This apparent improvement is not necessarily positive, it reflects rising delays in rural communities, where securing social care packages is often harder.
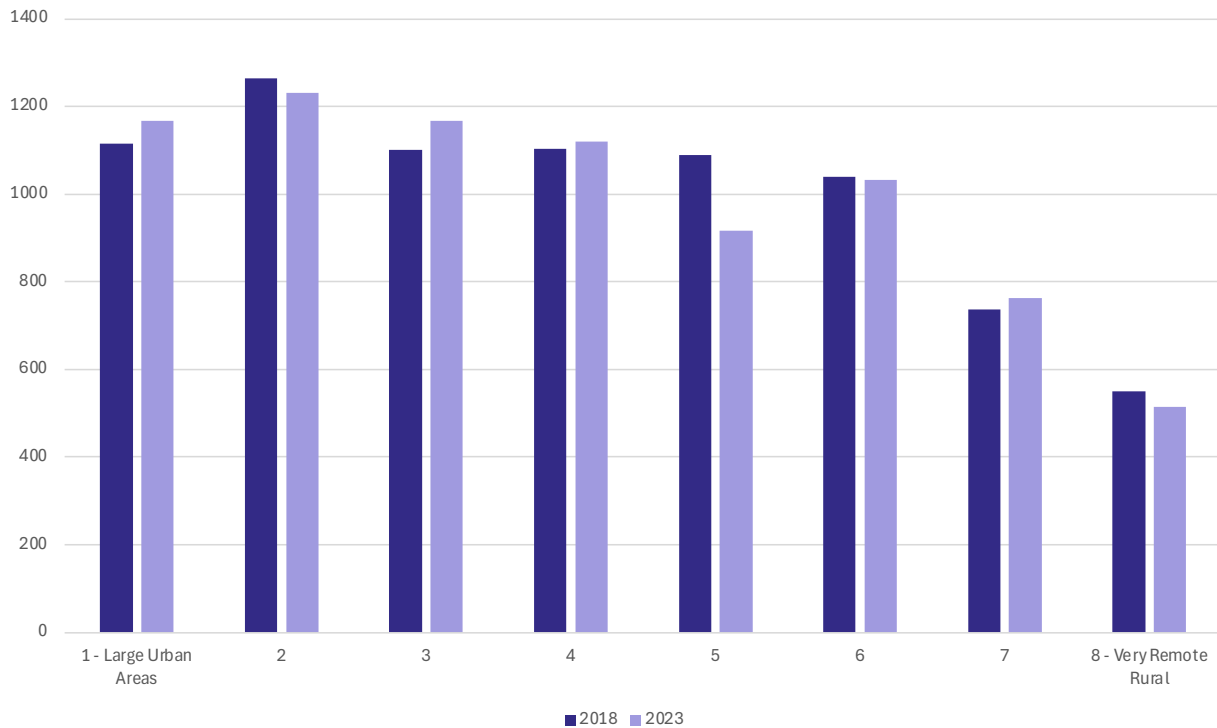
These patterns show that inequalities in hospital care are persistent. For deprived communities, higher use reflects greater underlying illness and barriers to early intervention. For rural communities, it reflects the challenge of geography and constrained community and social care. In both cases, the result is poorer outcomes and heavier reliance on hospital-based care.

Disparities by Ethnicity and Protected Characteristics

Routine data on ethnicity, disability, sexual orientation, and other protected characteristics remains limited, making it difficult to assess patterns of inequality across the full population. However, evidence from other studies suggests that these groups often face additional barriers to accessing services, poorer experiences of care, and worse outcomes [85]. Better data collection and use are essential for tackling these gaps.

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Overall, Scotland has shown that bold prevention and promotion policies can deliver real health gains — from smoking bans to minimum alcohol pricing. Yet falling vaccination rates, limited progress on obesity, and persistent inequalities in access to care demonstrate how fragile these gains are. Failures to address substance misuse have also had devastating consequences for individuals and communities. Addressing the underlying drivers of these trends will be critical if the NHS is to reduce avoidable illness and narrow health gaps in the years ahead, ensuring that every community benefits equally from progress.

Figure 35. Population served per GP (headcount)

Source: Public Health Scotland, "General practice - GP practice list sizes"

Figure 36. Relative difference in attendance and admission rates - Most vs least deprived quintile

Source: Public Health Scotland, "Acute hospital activity and NHS beds information"

Figure 37. Relative difference in attendance and admission rates - Urban vs rural areas

Source: Public Health Scotland Information Request

Part 2:

Drivers of Performance

Chapter 5.
Resources and Productivity

This report has so far examined how the NHS is performing and the outcomes it delivers for the people of Scotland. This chapter analyses the underlying drivers that explain these trends. It considers the resources to meet the demand, the pressures that shape it, and the impact on the workforce. Understanding these forces is essential to charting a realistic path for improvement.

Financing the System

Funding levels are high by historic standards, yet the relationship between spending and service delivery has weakened. Understanding how resources are deployed — not just how much is spent — is crucial. The health and social care budget is around one third of the total Scottish Government budget, and close to half of day-to-day spending [86].

Compared with England, Scotland has historically spent more per head on health, though the gap has narrowed in recent years, from around 17% in 2006/07, to just 2% by 2023/24 (Figure 38). A similar pattern holds when health and personal social services are combined. Spending was 15% higher in 2006/07 but only 5% higher by 2023/24 [87]. This narrowing partly reflects the decisions made by the Scottish Government in its spending priorities, as it increasingly spends on other devolved matters [88].
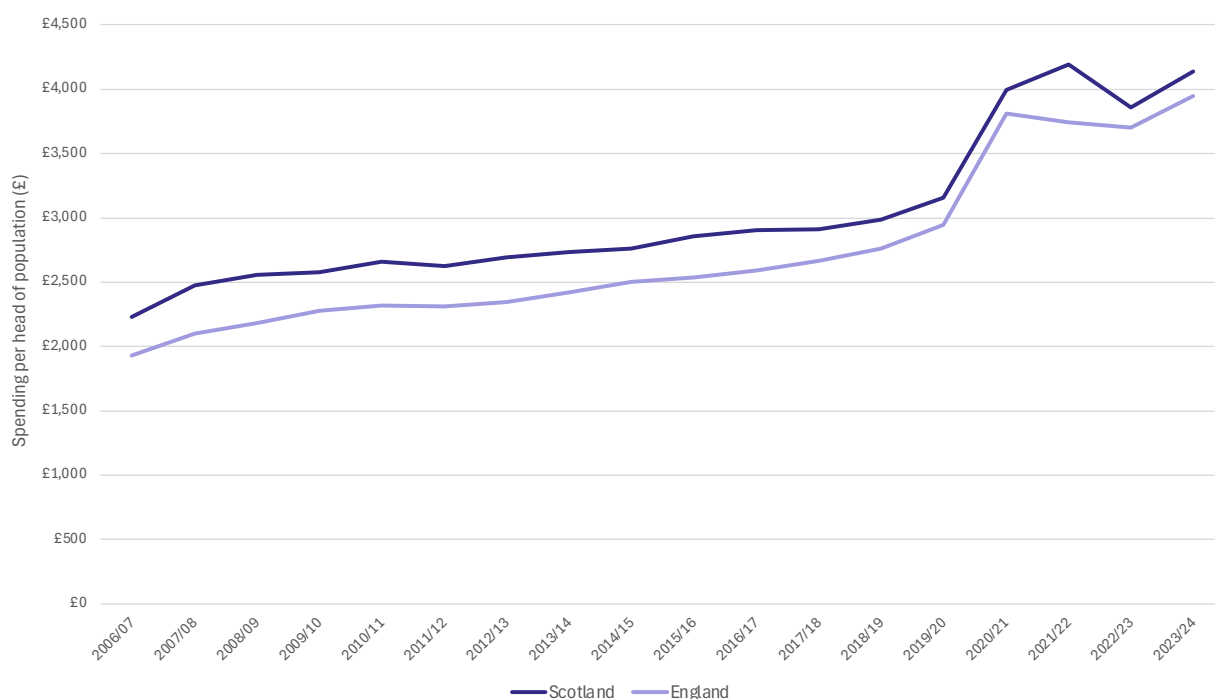
Beyond overall levels, how money is allocated across services is equally important, if not more so in times when resources are constrained. For decades, there has been a stated ambition to shift the balance of care from hospitals into the community, reflecting the reality set out above that the greatest gains to be made are through early intervention and better care in the community.

In practice, this transition has been modest. Hospital services accounted for 58.6% of the overall healthcare budget in 2005/06, falling only slightly to 56.5% by 2023/24 — the same level recorded in 2010/11. In contrast, spending on community health services rose from 12.3% to 21.7% over the same period (Figure 39), with much of the increase concentrated during the pandemic years, when resources were redirected to surveillance and vaccination programmes [89]. Outside of Covid-19, the main cost driver has been staffing. Although resource allocation has increased for community health services, key areas such as district nursing, health visiting and GP out of hours actually saw reductions in proportional spend compared with 2010/11.

Squeezed resources have fallen most heavily on family health services, which include general practice. Their share of total spending dropped from 25.7% in 2005/06 to just 19.2% in 2023/24. In real terms, spending on primary care has been effectively flat (Figure 40), creating a real-terms gap of around £290 million despite rising demand according to BMA Scotland [90]. While the new funding deal agreed with GPs will see this reduce, the additional £249m by 2028/29 will not completely close the gap [91].

Staffing costs now dominate the health budget. In 2023/24, hospital and community staffing accounted for more than 52% of the NHS budget, up from around 48% before the pandemic. This reflects both rising demand and recent pay settlements intended to offset years of below-inflation increases during the 2010s, as well as cost-of-living pressures [92].

Figure 38. Combined health and personal social services spend per head

Source: UK Government, "HMT Public Expenditure Statistical Analyses (PESA)"

Figure 39. Balance of costs

Source: Public Health Scotland, "Scottish health service costs"

Figure 40. Spending on primary care services - real terms change from 2005/06

Source: Public Health Scotland, "Scottish health service costs"

Energy bills have become another notable financial pressure. In 2023/24, 1.25% of the health budget was spent on energy — 76% higher than in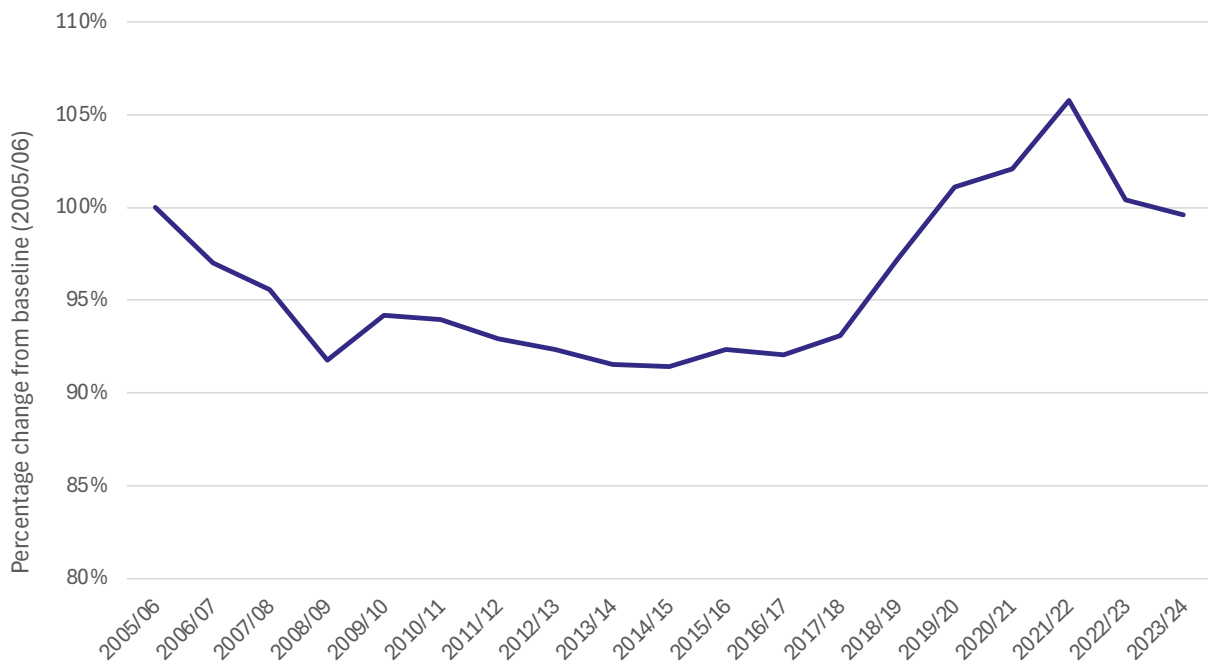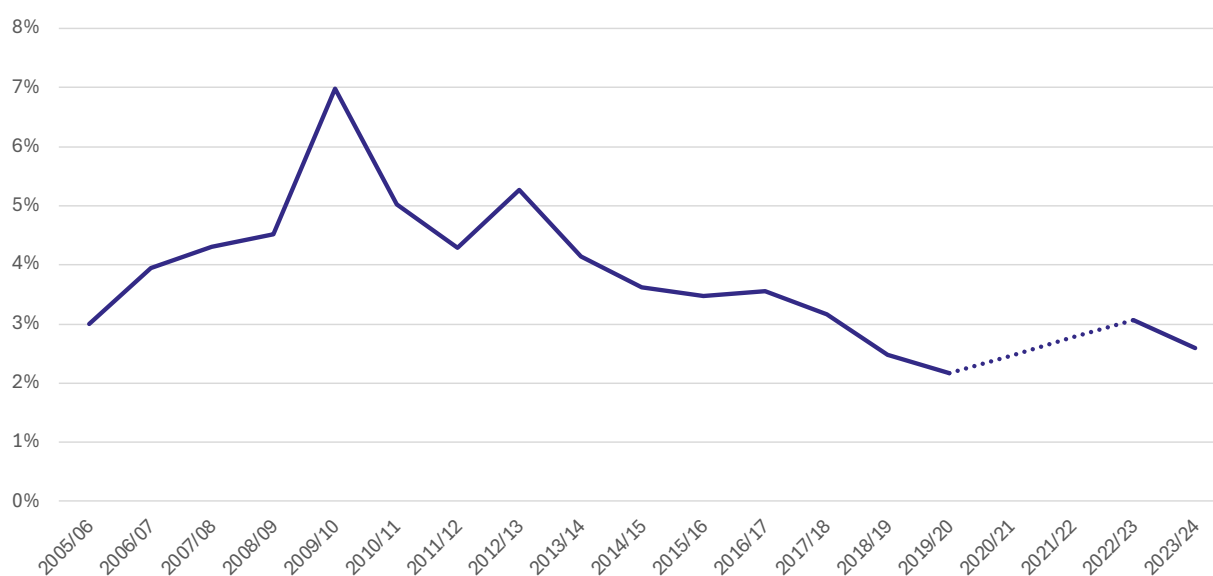 2020/21 — largely due to the conflict in Ukraine and wider volatility in global energy markets. While higher than recent years, this level is not unprecedented. In 2012/13, energy costs consumed 1.18% of the budget. The difference between then and now — around £12 million — highlights how external shocks can reshape spending, at least in the short term (as the expectation is that energy costs will ease in the longer term).

Meanwhile, spending on maintenance has declined. From 1.47% of the budget in 2008/09, it fell to 1.21% in 2023/24 — a cut of around £44 million each year. This decline has coincided with a rising backlog of estate repairs, which reached £1.5 billion in 2025/26. Of this, 7% (almost £106 million) is classed as high-risk.

Underinvestment in maintenance increases the risk of facilities becoming unusable. Between 2% and 2.5% of planned operations are cancelled each year for non-clinical reasons [93]. Around 16% of operating theatre hours are unused, a proportion of which will be due to non-clinical reasons.

While day-to-day spending has grown, capital budgets have fallen as a share of total spend. Between 2010/11 and 2019/20, capital expenditure averaged 3.8% of the budget; by 2023/24, this had dropped to 2.6% (Figure 41). This shift limits the system's ability to invest in infrastructure and equipment.

Figure 41. Proportion of NHS budget on capital expenditure

Source: Public Health Scotland, "Scottish health service costs"

The impact is visible in diagnostic capacity. Despite Scotland's pioneering history in medical imaging — home to the world's first radiology department in 1896, the invention of ultrasound in the 1960s, and the first full-body MRI in the 1980s — it now lags behind international comparators. Scotland has 8 MRI scanners and 12 CT scanners per million people [94], compared with OECD medians of 20 and 27, respectively [84]. A large proportion of existing machines are beyond their recommended lifespan. 28% of MRIs are more than 10 years old, with 9% exceeding 15 years, while 17% of CT scanners are over 10 years old, with 4% beyond 15 [95].

Ageing and limited diagnostic equipment contribute to downtime, capacity bottlenecks, and ultimately longer waits for testing. Underinvestment in capital is therefore not just a financial issue, but one that directly affects patient access, experience, and outcomes.

Service Utilisation

Scotland has fewer hospital beds today than it did a decade ago. While medical beds have increased slightly — up 4% between 2010/11 and 2023/24 — there have been significant reductions in surgical beds — down 20% over the same period — as well as in mental health and older adult services [31].

At a population level, the number of available beds fell from 47 per 10,000 people in 2010/11 to 37 per 10,000 in 2020/21, before stabilising. Acute services — medical and surgical beds combined — have been more stable, falling only from 27 per 10,000 in 2010/11 to 25 per 10,000 in 2023/24 (Figure 42). Beneath this stability lies the shift in more medical beds and fewer surgical beds.

A smaller bed base need not be a problem if average length of stay falls, more care is shifted safely into the community, or the population becomes healthier. In Scotland, none of these conditions are being met. As discussed in earlier chapters, average length of stay has risen, demand for acute services remains high, and the population is ageing with higher rates of long-term conditions. In practice, this means that fewer people are being treated, despite sustained demand.

The result is high and rising occupancy. In 2010/11, acute specialties were already stretched, with occupancy at around 84%. By 2023/24, this had climbed to 87% overall — with medical beds consistently above 90% and surgical beds around 81% (Figure 43). Health systems typically aim for an occupancy rate of around 85% [96]. At such levels, even small surges can gridlock the system.

Productivity

Scotland lacks a single headline productivity measure like those published by the Office for National Statistics (ONS) and NHS England. However, from the analysis conducted for this report, the evidence suggests the NHS Scotland is in the grip of a productivity squeeze. We have spent more, staffed more, but have not delivered more care.

Before the pandemic, NHS productivity in hospitals was rising slowly, driven by more admissions and shorter average length of stay. The Covid-19 pandemic brought that to a halt. Since then, activity has only partially recovered, despite sharp increases in staffing and spending. The result is that today, the NHS is delivering less care for more input than it did just a few years ago.

The pattern varies across services. In general practice, activity has increased 18% since 2018 despite a static workforce, reflecting expanded multidisciplinary teams and digital access. By contrast, in hospitals, the pattern is reversed: consultant numbers rose by over 15% and qualified nurses by nearly 12% between 2018 and 2025, yet emergency admissions are still 2.5% smaller and elective and day-case admissions are 9% smaller in 2023/24 compared with 2018/19. In hospitals, more staff have not translated into more patients treated.
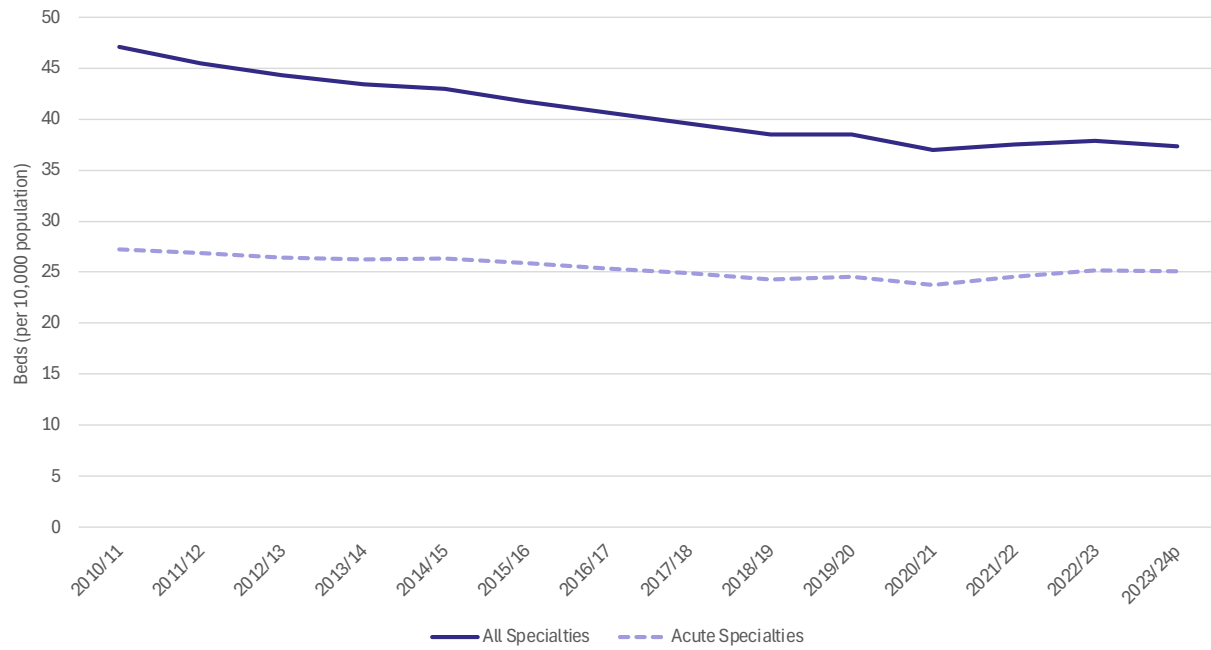
A combination of structural pressures is reshaping the balance. Falling bed numbers limit throughput. Patients admitted are older and have more complex needs, staying longer and requiring more intensive care [31]. Delayed discharges keep beds occupied even when patients are ready to leave. Rising staff costs absorb more of the budget without adding capacity. Together, these factors mean that increases in staffing and spending are swallowed up by complexity rather than converted into higher activity.

The wider lesson is that Scotland's NHS faces a structural productivity gap. Instead of pushing more resources into hospitals, policy needs to focus on removing the blockages, in prevention, primary care, and community-based care services, that currently trap staff time and funding in crisis management. Until that gap is closed, the paradox will remain: more money and more staff, but less care delivered.

Despite record levels of spending and a growing workforce, the productivity of the health service has stalled. Additional funding has sustained activity but not transformed capacity, largely because the system's most important resource — its people — is under increasing strain.

Productivity depends not only on funding and infrastructure but on the people who deliver care. The most significant pressures now lie in the workforce itself. Understanding how staffing levels, skills, and morale interact with system pressures is essential to explaining Scotland's productivity challenge.

Figure 42. Number of hospital beds per 10,000 population

Source: Public Health Scotland, "Acute hospital activity and NHS beds information"

Figure 43. Hospital occupancy rate

Source: Public Health Scotland, "Acute hospital activity and NHS beds information"

Chapter 6.
Staffing

While hospital capacity has steadily declined, the NHS workforce has expanded in both size and cost. Yet this growth has not translated into greater resilience or higher productivity.

Between 2010 and 2025, whole-time equivalent (WTE) medical and dental staff increased by 38%, driven largely by a 42% rise in consultants [97]. This growth has been concentrated in hospitals — GP headcount has remained static over the same period (Figure 44) — making it highly unlikely that the Scottish Government's target of an extra 800 GPs by 2027 will be met. It is currently estimated that they will be a staggering 650 short of target [98].

Despite this expansion, shortages persist. Official statistics report around 400 consultant vacancies (a 7% vacancy rate), but BMA Scotland actually estimate this to be closer to 1,000 unfilled posts — equivalent to a 14.4% rate — once long-term, unadvertised, and locum-covered roles are included [99]. Anaesthetics, general psychiatry, and clinical radiology have the greatest shortages. Vacancy rates also vary widely: Glasgow and Lothian report less than 4%, while the Western Isles, Shetland, and Orkney exceed 30%, leaving some areas with chronic gaps in provision. Persistent vacancies in core specialties undermine elective recovery and widen regional inequalities in access.

Although the number of consultants continues to rise, with more joiners than leavers each year, retention challenges persist. Among those who left the NHS entirely between April 2024 and March 2025, 43% were aged under 55 [100], suggesting mid-career burnout rather than natural retirement. Without addressing workload and work-life balance, workforce growth will be unsustainable.

Nursing WTEs increased by 15.6% between 2010 and 2025, with qualified nurses up 14.8%. Vacancies remain around 2,100 posts, roughly 4% of the workforce, similar to pre-pandemic levels after a sharp spike in 2022/23. Unlike medical posts, vacancy rates are relatively even across boards, with all reporting less than 9%. Nursing headcount continues to rise, with over 1,100 more nurses joining the NHS than leaving between April 2024 and March 2025. However, 54% of those who left were under the age of 55, suggesting persistent difficulties in retaining mid-career staff. Retention, not recruitment, is now the defining workforce challenge.

Sickness absence remains a major factor affecting workforce capacity. Rates have risen steadily from 5% in 2015 to 6.4% in 2025 (Figure 45), with mental ill health a leading cause [101]. Sickness
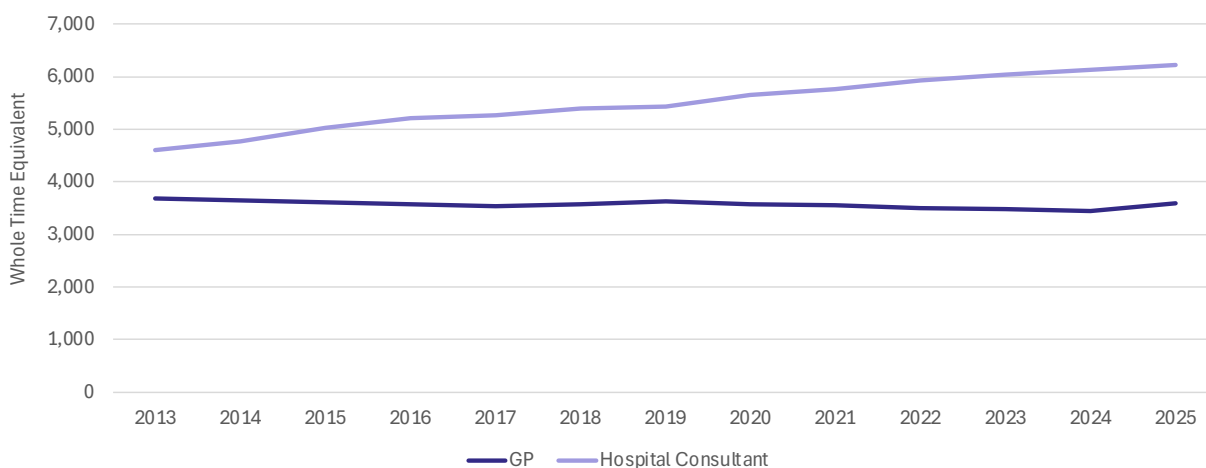
absence for mental health reasons has increased from 21% in 2016/17 to 28% in 2024/25, equivalent to an additional 1.2 million hours lost. NHS staff are around 50% more likely than the general population to experience chronic stress, linked to staff shortages, high workload, and pressure to maintain quality care [102]. These pressures contribute to burnout and higher turnover. This cycle of stress, sickness, and turnover erodes productivity and service quality even when staffing numbers look adequate on paper.

To cover vacancies and sickness absences, the NHS has become increasingly reliant on bank, agency, and locum staff. Spending on temporary nursing staff has risen gradually over time, surged during the pandemic, and by 2025 costs more than £400 million a year.

For medical staff, the proportion of expenditure on bank staff across the 14 territorial health boards has grown from 0.6% in 2015/16 to 2.6% in 2024/25. Over the same period, reliance on locums has fallen from 6.5% to 3.8% (Figure 46) [103].

For nursing, the shift has been even starker. Bank spend increased from 5.8% in 2015/16 to 8.7% in 2024/25. Agency use, which was typically stable at around 1% of expenditure before the pandemic, spiked to 4.4% in 2022/23 before falling back to pre-pandemic levels in 2024/25 (Figure 47). Taken together, around 10% of all nursing staff costs are now devoted to temporary contracts [103].

Figure 44. GP vs hospital consultant WTE

Source: NHS Education for Scotland, NHS Scotland Workforce publication

Figure 45. Sickness absence rate

Source: NHS Education for Scotland, NHS Scotland Workforce publication

Figure 46. Medical type spend as % total medical spend

Source: NHS Health Board FOI Data

Figure 47. Nurse type spend as % total nurse spend

Source; NHS Health Board FOI Data

While the ability to draw on bank, agency, and locum staff provides flexibility, it also places additional pressure on budgets and undermines workforce stability. High reliance on temporary cover can disrupt continuity of care for patients and adds to the strain on permanent staff, who are often required to orient and support short-term colleagues. Continued dependence on temporary staffing risks becoming a symptom of deeper workforce planning failures.
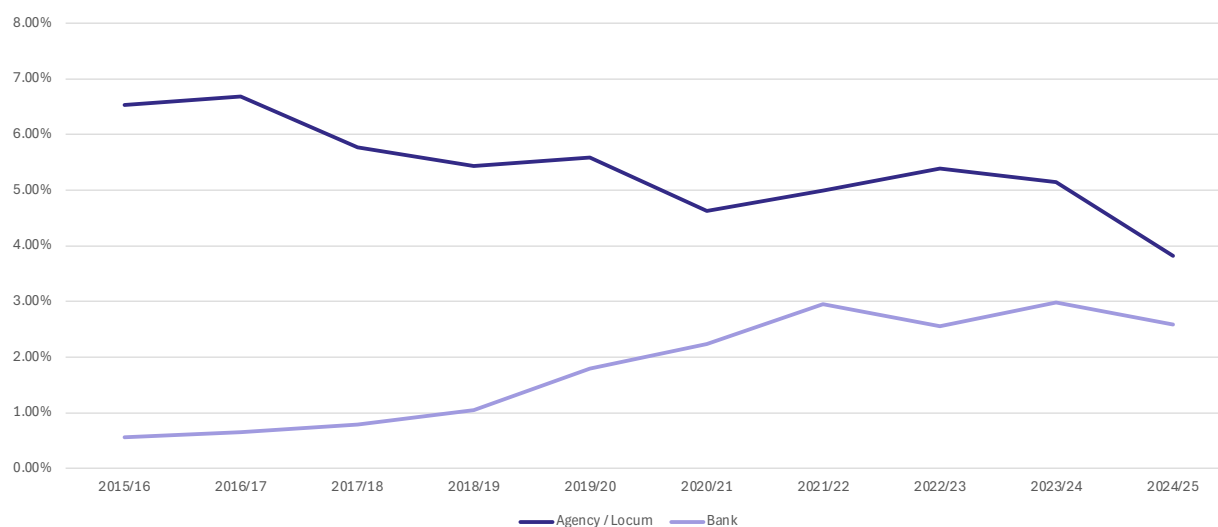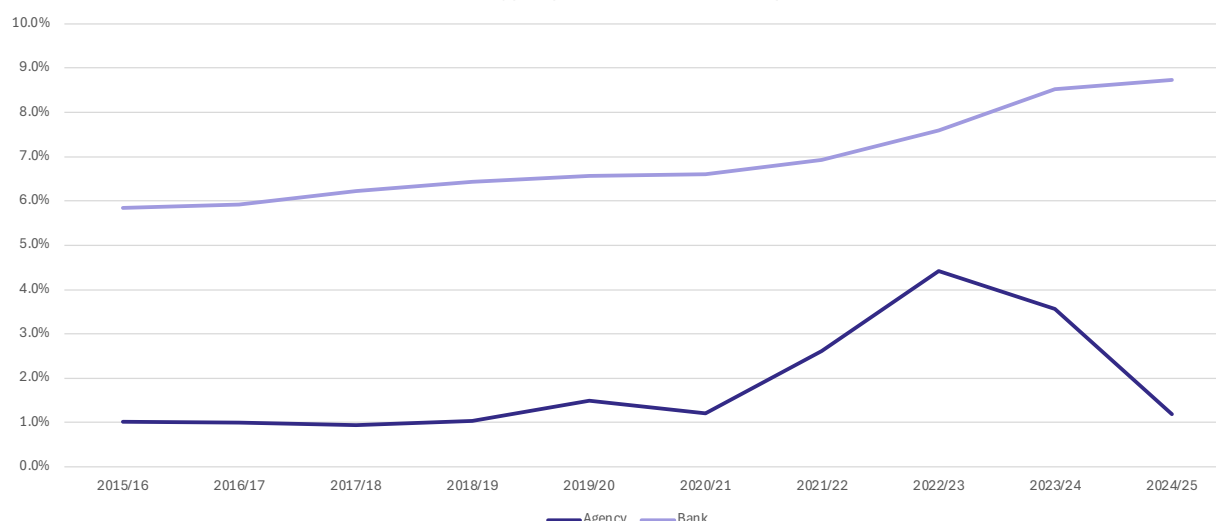
Less is known about management staffing in Scotland, but evidence from elsewhere suggests services are under-managed at a local hospital level [104]. Insufficient management capacity can weaken coordination across hospital sites, slow elective care, and exacerbate bottlenecks in patient flow. It also places a greater operational burden on clinical staff, who often pick up tasks outside their core roles.

Although not easy to capture in data, there are also signs of morale problems that can be exacerbated by attempts to cope with demand pressure. A number of reports, including independent reviews and inspections reports from Healthcare Improvement Scotland, have provided evidence of staff in some services operating under problematic cultures that discourage the raising of issues or shut down concerns, even when regarding patient safety. [105] [106] [107]. Such issues were also highlighted by independent reviews pre-pandemic [108] and are not limited to a single health board or service. This lack of support can intensify stress, contributing to the cycle of burnout and sickness absence already seen across the workforce.

The NHS workforce has grown faster than at any time in its history, yet morale and productivity are under strain. Vacancies, sickness absence, and high turnover erode the benefits of expansion, while reliance on temporary staff undermines stability. The workforce is the system's greatest resource, but also its most fragile. Restoring balance will require renewed focus on retention, wellbeing, and leadership — turning numerical growth into sustainable capacity.

Chapter 7.
Governance, Systems, and the Implementation Gap

Many of the pressures described are shaped by the governance and political systems within which NHS Scotland operates. This chapter sets out the system issues facing the NHS and the rise of the implementation gap. It focuses on how governance, political factors, financial structures, and organisational culture interact to shape outcomes.

There have been more than 130 major health and care policy documents published between 2007 and 2025 — roughly one new strategy every seven weeks. These include landmark initiatives such as health and social care integration, strategies on mental health and cancer care, and repeated plans to tackle waiting times. Despite this extensive policy output, as has already been shown, Scotland remains largely hospital-centric, key access targets are being missed, and population health outcomes are stagnating or in decline. The challenge is not a shortage of ideas but a persistent failure to implement them.

As far back as 2005, the Kerr Report called for a decisive shift from hospital-based treatment to care delivered closer to home. Kerr argued that without such a shift, hospitals would become overwhelmed and outcomes would stagnate [109]. While widely praised at the time, implementation was partial at best. Nearly two decades on, many of the challenges Kerr identified remain unresolved and that transition remains incomplete.

The Feeley Report on social care in 2021, some 16 years later, highlighted the consequences of this failure to act. It estimated that around 36,000 people in Scotland were not receiving social care support that would benefit them, with an annual cost of around £436 million required to close the gap [110]. The result is that unmet need persists in the community, hospitals absorb the pressure, and the very rebalancing envisaged by Kerr remains unfinished.

These cycles of report, consensus, and inertia have created fatigue within the system and scepticism among staff and the public.

Governance

Scotland's health and care system operates within a dense institutional landscape: three regional planning bodies, 14 NHS territorial boards, seven specialist boards, one national public health body, 32 community planning partnerships and 31 integration authorities. Territorial boards are formally independent but must work within tight Scottish Government parameters, including annual delivery plans, three-year financial frameworks, and ministerial sign-off for major service change [111].

Integration Joint Boards (IJBs) were designed to coordinate health and social care, but in practice their performance is uneven. Some areas have developed effective mechanisms for joint planning, while others report unclear responsibilities, uneven relationships between health board and council members, and difficulties in sharing information [112]. This has led to variability in how integrated care is delivered. Patients in some areas benefit from smoother transitions between hospital and community services, while in others the lack of coordination leads to duplication, delays, and gaps in care.

Financial structures reinforce the status quo. Annual budgeting and earmarked pots restrict flexibility. Boards cannot easily shift funding from emergency care to primary or community settings. Short-term performance targets, particularly waiting times, dominate priorities and reward crisis management [113] [114]. Similar trends can be seen in availability of data and the performance metrics that are measured. While there is a wealth of data on acute care, there is not a similarly rich collection of data for primary care or community-based services. This diverts attention and resources away from upstream investment in prevention, rehabilitation, or community support that could reduce future hospital demand. In effect, the system of financial and performance monitoring sustains the hospital-centred model that policy rhetoric aims to replace.

Use of New Technologies

The Scottish Government has a Digital Health and Care Strategy, but digital access and use of technology to enable efficiencies have lagged behind progress elsewhere.

The shift to towards virtual consultations in primary care is to be welcomed and there has been use of virtual and digital solutions in services such as diabetes management, dermatology, and Hospital at Home. More broadly though, delivery at scale and digital access for the most commonly used NHS services has been limited, with many projects facing delays and challenges to implementation [115].

A digital app for NHS primary care services has been available to the public in England since 2019 but was only first committed to in Scotland in 2021. The time line for development suggests that

full public rollout will only commence in 2026 and implementation of all planned services such as appointment booking and medical records access will only be complete by 2030 [116]. Similarly, rollout of e-prescribing in Scotland was only due to be completed in 2026 [117], while GPs in England have had fully digitised prescribing since the 2010s.

Political Dynamics

Political factors exacerbate structural challenges. Scottish politics has been dominated by global crises, constitutional debates and external shocks — from the 2008 financial crash, the 2014 independence referendum, and Brexit, to the Covid-19 pandemic and global inflation crisis. These absorb political capital and encourage short-termism, as ministers and civil servants are pulled toward immediate imperatives rather than focussing on long-term health reform.

Capacity constraints add to the challenge. Scotland's public sector is disproportionately larger than elsewhere in the UK, but the central civil service is stretched more thinly across Scottish Government ministers compared to in Whitehall [118]. Responsibility for delivery of policy is dispersed across various territorial and special boards — leaving the system more stretched and less able to drive sustained implementation of complex health policies.

Media dynamics further shape the system's culture. With many news organisations reducing localised output and therefore coverage of local government, attention is concentrated on Holyrood. This creates powerful incentives for visibility over delivery; for example, the publication of a new strategy attracts more political and media attention than its actual implementation [118]. The sheer volume of policy launches risks crowding out follow-through, as ministers seek to satisfy the demands of the news cycle.

The consequence is a system better at generating policy than executing it.

The Implementation Gap

These governance, political, financial, and cultural dynamics combine to create a persistent implementation gap. The Health Foundation's 2023 review of health inequalities described this gap as one of Scotland's defining policy challenges.

In its survey, 82% of stakeholders said policy implementation was a large or very large problem. They attributed this to short-termism, centralised policy-making, poor use of money, weak evaluation and scaling, and a lack of coherence across policy areas [14]. The review also identified deep-seated trust issues between national and local government, agencies, and the voluntary sector, alongside a fear of failure that suppresses innovation.

Audit Scotland has reached similar conclusions. Its 2024 report warned that without a clear national strategy, strengthened governance, and integrated capital planning, boards will remain unable to innovate or reallocate resources at scale. The Auditor General concluded bluntly that there is "no clear plan to deliver the NHS vision" [119].

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Together these dynamics mean that Scotland often knows what needs to be done: shifting resources to primary and community care, investing in prevention, tackling health inequalities. The barrier is not consensus but delivery.

What the system lacks is capacity in crucial areas, political space, and strong governance to deliver at scale. The result is that population health indicators stall, hospital pressures mount, and resources are repeatedly consumed downstream rather than invested upstream where they could have the greatest long-term impact. Without closing the implementation gap, new strategies will continue to add to the pile rather than change the trajectory.

Conclusion:
The Way Forward

The NHS in Scotland is one of the country's most valued institutions. Every day, it delivers high-quality care in many areas, yet persistent pressures and structural challenges constrain its ability to meet demand and improve population health equitably.

Rising preventable admissions, delayed discharges, and high hospital occupancy highlight a system under strain, while falling patient satisfaction and increasing reliance on private care reflect growing public concern. Health outcomes remain uneven; avoidable mortality is disproportionately high in deprived communities, and inequalities persist across geography, socioeconomic status, and ethnicity.

Scotland has achieved measurable gains in health protection and promotion, such as reductions in alcohol-related harms and smoking prevalence. However, declining vaccination coverage, limited progress on obesity, and widening disparities underscore how fragile these gains remain.

The NHS workforce has expanded, yet persistent vacancies, reliance on temporary staff, and rising burnout reveal systemic workforce pressures that undermine service delivery and continuity of care.

Financially, Scotland spends more on health than at any point in its history, yet productivity has stalled. Capital investment has fallen, infrastructure is ageing, and diagnostic capacity lags international peers.

Beneath many of these challenges is the "implementation gap" — the recurring failure to translate clear policy intent into sustained action. Scotland has repeatedly identified the reforms and investments needed, from shifting care closer to home to addressing inequalities, but governance, political short-termism, fragmented structures, and limited operational capacity prevent consistent delivery at scale.

Closing that gap is Scotland's central challenge. It will require:

- Long-term planning and accountability, with financial frameworks that reward prevention and community care.

- Stronger leadership and vision for the future, with decluttered governance structures and empowerment of local leaders to innovate and address challenges.

- Investment in data, management, and evaluation, to learn what works and spread success.

- A renewed focus on equity, ensuring that resources flow to those with greatest need.

The NHS faces a structural paradox: more staff, more funding, and more policy initiatives, yet continued inefficiencies, persistent inequalities, and constrained productivity mean that patient outcomes and experience are not improving in line with expectations.

Addressing this will require a coordinated focus on upstream investment, stronger governance, integrated planning across health and social care, and targeted action to close inequalities, ensuring that resources reach the people and communities that need them most.

More of the same will not do. The way forward is not another new strategy, but consistent, evidence-led implementation — a health system that learns, adapts, and acts for the long term.

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