OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 26 March 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 26 March 2019

CONTENTS

HEALTH AND SPORT COMMITTEE
10th Meeting 2019, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

John Brunton (Scottish Government)
Dr Jane Burns (NHS Lanarkshire)
Calum Campbell (NHS Lanarkshire)
Dr Linda Findlay (NHS Lanarkshire)
Joe FitzPatrick (Minister for Public Health, Sport and Wellbeing)
Heather Knox (NHS Lanarkshire)
Neena Mahal (NHS Lanarkshire)
Ross McGuffie (NHS Lanarkshire)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 26 March 2019

[The Convener opened the meeting at 10:00]

European Union (Withdrawal) Act 2018

Cross-border Health Care (EU Exit) (Scotland) (Amendment etc) Regulations 2019 [Draft]

The Convener (Lewis Macdonald): Good morning and welcome to the 10th meeting of the Health and Sport Committee in 2019. I ask everyone in the room to ensure that their mobile phones are on silent.

Agenda items 1, 2 and 3 are consideration of an instrument related to the European Union (Withdrawal) Act 2018: the draft Cross-border Health Care (EU Exit) (Scotland) (Amendment etc) Regulations 2019. The purpose of the instrument is to amend the National Health Service (Scotland) Act 1978 and the National Health Service (Cross-Border Health Care) (Scotland) Regulations 2013. The changes remedy deficiencies in retained European Union law relating to cross-border healthcare in circumstances in which the United Kingdom leaves the EU without a withdrawal agreement in place.

The instrument provides a mechanism for ensuring that there is no interruption to healthcare arrangements for people accessing healthcare under EU Directive 2011/24 after exit day in those European Economic Area member states that agree to maintain the current arrangements in place with the UK for a transitional period until 31 December 2020.

We will consider first the categorisation of the instrument. Members will be familiar with the basis on which that is done. The Scottish Government has laid the instrument under the mandatory affirmative procedure. Legal advice suggests that the sift should have been applied, but that, had that been the case, the instrument would still have been laid under affirmative procedure. Ultimately, the practical effect is the same.

The Delegated Powers and Law Reform Committee considered the instrument on 19 March 2019 and agreed that it had been appropriately categorised as being of medium significance. The Delegated Powers and Law Reform Committee drew the instrument to the attention of the Parliament under the general reporting ground, as it contains a minor error, and called on the Scottish Government to correct that error at the next legislative opportunity.

As I said, the instrument has been categorised as medium, because of its impact. Are members content with that categorisation?

Members *indicated agreement.*

Subordinate Legislation

Cross-border Health Care (EU Exit) (Scotland) (Amendment etc) Regulations 2019 [Draft]

10:03

The Convener: Agenda item 2 is evidence on the instrument from the minister and his officials. After they have answered members' questions, we will move to the formal debate on the motion.

I welcome to the committee Joe FitzPatrick, Minister for Public Health, Sport and Wellbeing, John Brunton, senior policy manager, and John Paterson, solicitor, from the legal directorate of the Scottish Government. I believe that the minister wishes to make a short opening statement.

The Minister for Public Health, Sport and Wellbeing (Joe FitzPatrick): I am pleased to join the committee this morning to discuss the regulations. It is the Scottish Government's clear position that the interests of Scotland would be best served by remaining in the European Union. Recent events in Whitehall have served only to strengthen that view. However, as a responsible Government, we have a duty to make the necessary preparations to ensure that the Scottish statute book remains operable to help to mitigate the considerable damage that a no-deal Brexit would cause.

At present, under the European Union cross-border healthcare directive, European Economic Area citizens have the right to obtain healthcare services in other EEA countries. However, the treatment must be the same as, or equivalent to, the treatment that is provided by the state in their country of affiliation. The patient pays for the treatment up front and may claim reimbursement, limited to the amount that the treatment would cost had it been provided by the state at home—in Scotland, that would be treatment on the NHS.

As healthcare is devolved, the National Health Service (Cross-Border Health Care) (Scotland) Regulations 2013 implemented the directive in Scotland where necessary. The regulations provide a legal basis for the NHS to apply the need for prior authorisation for expensive specialist treatment. They also limit the amount of reimbursement to the cost to the NHS had the treatment been provided here.

Importantly, the home state retains responsibility for the healthcare that it funds on a cross-border basis. If the treatment is not available on the NHS in Scotland, patients cannot use the directive to receive it in another EEA country and claim reimbursement from the NHS in turn.

The Cross-border Health Care (EU Exit) (Scotland) (Amendment etc) Regulations 2019 are taken from powers within the European Union (Withdrawal) Act 2018. They correct deficiencies that would arise from the UK's withdrawal from the EU without a deal by modifying the 2013 regulations. England, Wales and Northern Ireland are introducing similar regulations.

The regulations protect patients in a transitional position and enable continuation of cross-border healthcare arrangements in those countries with which the UK has established continued reciprocal arrangements, maintaining the provisions in the directive that gives EEA citizens the choice to travel for healthcare.

Maintaining effective access to cross-border healthcare abroad requires basic reciprocal agreements to ensure that the existing EU framework is maintained in participating countries. Therefore, the regulations terminate access to cross-border healthcare with countries where there is no longer a reciprocal agreement. As reciprocal healthcare arrangements are applied on UK-wide basis, the Secretary of State for Health will maintain a list of countries that reach agreement to maintain the current reciprocal arrangements with the UK until 31 December 2020.

The regulations protect, as far as possible, key groups of patients in a transitional situation on exit day, irrespective of any reciprocal agreement being in place. Examples include individuals who obtain prior authorisation for planned treatment before exit day but who have not yet obtained treatment; individuals who accessed healthcare abroad prior to exit day but who have not yet completed their treatment or sought reimbursement; and UK state pensioners from Scotland who are living in other EEA countries and need to access healthcare provided by the NHS while they are in Scotland.

These time-limited measures aim to prevent, as far as possible, without reciprocal agreements, a sudden loss of overseas healthcare rights for Scottish residents and pensioners from Scotland residing in the EEA. We consider the amendments to be technical for the most part.

I hope that members will agree that, as part of the Scottish Government's overall programme of legislative contingency planning for Brexit, the Cross-border Health Care (EU Exit) (Scotland) (Amendment etc) Regulations 2019 provide necessary changes to protect Scottish residents' rights to access cross-border healthcare in other EEA countries, as far as that can be achieved.

We are happy to answer questions.

The Convener: Thank you. Minister, you talked about continued reciprocal arrangements with

other countries in the European Economic Area. Can you update the committee on which countries the UK Government has made progress with in reaching such agreements?

Joe FitzPatrick: We are not aware of any formal bilateral agreements as yet, but we understand that some EEA countries have agreed in principle to reciprocal agreements. I think that Spain is the only country that has made that public and, as I understand it, has drafted regulations. However, it should be made clear that the European Commission has said that it considers discussions in the second phase of negotiations to be the appropriate way to reach agreement on the future of reciprocal healthcare, and it has indicated that it does not encourage bilateral agreements at this time. In spite of the fact that there are indications, particularly from Spain, there could be a hiatus. The Cross-border Health Care (EU Exit) (Scotland) (Amendment etc) Regulations 2019 will protect Scots who have travelled for treatment but have yet to receive it, or who have received treatment and are seeking reimbursement in the intervening period.

The Convener: On the expectation on the EU's part that there will be a withdrawal agreement, it is understandable that the European Commission does not wish to promote the concept of bilateral agreements at this stage. In the absence of an agreement, which is clearly a possibility against which the regulations are designed, immediately on exit day—whichever day that might be—the existing arrangements would cease and, therefore, bilateral arrangements would be required for UK citizens abroad, would they not?

Joe FitzPatrick: There is a clear willingness from Spain that that should happen and, as I said, I understand that the regulations are already drafted. However, the European Commission's view is that, irrespective of the outcome of Brexit, any reciprocal agreements should be pan-European. There are perhaps two different views coming from Europe, which is why it is important that we put the regulations in place.

The Convener: I understand that point. Given that the EEA includes a number of countries such as Norway and Switzerland that are not members of the European Union, what progress has been made on bilateral arrangements with those countries? Norway is obviously very important to Scotland from the perspective of the oil industry.

Joe FitzPatrick: Reciprocal agreements are a reserved matter. I understand that the UK Government is attempting to get reciprocal agreements in place. Until recently, we had not been given terribly much information about the discussions that have taken place, but we are starting to get a bit more information about that.

John Brunton (Scottish Government): The UK Government has entered into agreements with Switzerland, Liechtenstein, Norway and Iceland, so there will be reciprocal agreements with those countries.

The Convener: I assume that, at the point at which formal arrangements are agreed, that will be made public.

John Brunton: Yes.

The Convener: What guidance will be issued to NHS boards and, potentially, to individuals on the operation of the instrument?

Joe FitzPatrick: We already have the European cross-border healthcare national contact point, which was established when the directive was transposed into domestic legislation in 2013. Our intention is to retain that contact point and to update it to include the provisions in the amendment regulations that underpin the instrument, and that information will be in the guidance that will be issued to NHS boards.

I will elaborate on how the contact point works. It is a web facility that is maintained by NHS inform, which is the information arm of NHS 24. It provides information for patients who wish to use a cross-border healthcare route for treatment overseas, and it contains contact details for the cross-border leads in each of our NHS boards. That service will be maintained and updated.

Emma Harper (South Scotland) (SNP): I am interested in patients who make a specific request to use the directive, under article 8. Does the minister know how many Scottish residents are awaiting treatment under the directive in other member states?

Joe FitzPatrick: The figures for the number of patients are collated on an annual basis and published in April, so last year's figures will be published this April. The latest figures that are available, which give us an indication of the sort of numbers that we are talking about, are from 2017 and were published last April. In that year, the figure was 29 people, so it was a relatively small number of folk, and we reckon that the cost was about £50,000.

I have with me a list of the countries that each of those 29 people came from but, if I read them out, there is a danger that I would identify them, because there were two people from one country, five from another, one from another, one from another and so on. There was one country with 16 people but, mainly, a small number of people made that choice. Those were the figures for 2017; we should get the numbers for 2018 at some point in April.

John Brunton: Yes. Every year, we get a questionnaire from the European Commission, via

the UK Government. We then go out to NHS boards, which provide the information that we need.

Emma Harper: We are talking about patients who are seeking healthcare and live in Scotland, but who might go to Spain, for example. Do the figures include patients who are seeking dialysis and might be wintering in Spain?

10:15

Joe FitzPatrick: That is a good question, but I do not think that it would be covered by the regulations. Currently, that matter would in the main be covered by the European health insurance card. It is an important question, but I do not think that there is a particularly good answer for people in that circumstance. The regulations do not replace the EHIC, although reciprocal arrangements could do that, if we get them—that will depend on what agreements we get. Whether Brexit day is 29 March, 12 April or some other time in the future, it is important that people understand what the implications are for them. For most people travelling, I guess that it will be about having insurance that covers them for all eventualities. You are talking about a particular group of people with medical conditions, for whom it might be difficult to get insurance.

Do you want to add anything, John?

John Brunton: Not really. I just point out that, in the short term, if someone is looking for dialysis when they are in Europe for two or three weeks, we might ask an NHS board to pick up the bill for that, under basic equality considerations. However, it would be down to individual boards whether they are prepared to fund that.

Emma Harper: We need to ensure that people are clear and understand what the reciprocal process entails. I had a constituency issue when a person who came from Cyprus needed dialysis in Ayrshire, and it was really complicated to try to organise that.

Joe FitzPatrick: When people voted in the referendum a number of years ago, that sort of detail was never discussed. You are making a good case for why we need another people's vote.

David Stewart (Highlands and Islands) (Lab): Emma Harper makes an exceptionally good point. Personally, I would be surprised if the EHIC covered dialysis abroad. Obviously, the minister will have figures on the number of EU nationals who receive dialysis under the EHIC, and I would be surprised if those numbers were substantial. The minister might not have that to hand, but will he ask health boards to provide us with the information? It seems to me that that is beyond the terms of the reciprocal agreement.

John Brunton: I do not think that that information is available, but the EHIC covers pre-existing conditions, which includes dialysis.

David Stewart: Sure, but the idea that if someone breaks their leg in Spain and goes into hospital they will get reciprocal healthcare is well understood, whereas that is not the case with the idea that someone can, using an EHIC, go into a hospital in Spain without any pre-authorisation and ask for kidney dialysis, which is what Emma Harper asked about. I would be surprised if that happens regularly without lots of prior authorisation.

Joe FitzPatrick: People will certainly want to ensure that they are aware of the support that they will get.

John Brunton: There would definitely be safety aspects, but it happens.

David Stewart: On the reporting, health boards in Scotland that provide care to EU citizens under EHIC need to communicate back to you information on the work that they have carried out.

Joe FitzPatrick: The regulations are not about EHIC, so I think that we are—

David Stewart: I did not raise EHIC; you did.

Joe FitzPatrick: But that is not what the regulations are about.

David Stewart: You raised the point, and I am just trying to confirm something. Do you have figures on that, or can you ask the boards to give a return on the number of patients involved?

Joe FitzPatrick: We will take that away and see what we can do.

Sandra White (Glasgow Kelvin) (SNP): In your opening remarks you mentioned agreements and consent with regard to England and Northern Ireland. Having read the letter that the Cabinet Secretary for Health and Sport sent to the committee on 21 March, I have great concern that the Scottish Parliament, Scottish ministers and the committee do not seem to have consent or agreement from Westminster on how the process will work. The convener had asked the cabinet secretary why we do not have delegated powers in this respect. The cabinet secretary mentioned that, like the Welsh Government, the Scottish Government

"places great importance on the protection of its devolved status and legislative competence."

The cabinet secretary said that she wrote to the appropriate minister at Westminster with a perfectly reasonable request with regard to the Scottish Parliament being given delegated powers. However,

"The UK Government has ... rejected this reasonable demand and there is little prospect of a reversal at this time."

Is there any follow-up from that, such as a memorandum of understanding? Will the matter come back to the committee? It is worrying that healthcare arrangements have been considered in the House of Lords at Westminster when they are a devolved matter, and that this Parliament has not been given legislative powers to deal with them.

Joe FitzPatrick: Let me make it absolutely clear that we think that devolution and the powers of the Scottish Parliament should be respected at all times. To say that the Scottish Government is not happy about the current arrangements would be an understatement. When we talk about devolved matters, it is important that we remember that that is not about the Scottish Government; it is about according the Scottish Parliament its place, and respecting it at all times. We were disappointed that the UK Government did not accept proposals that would have guaranteed our devolved powers.

That said, we must make a decision about what is in the interests of the people of Scotland, which is why we are taking a pragmatic approach and have laid regulations that will protect the small number of citizens who could find themselves in a difficult place if we did not.

Sandra White: I understand that you want to make the transition smooth and seamless. However, at the moment we do not even know whether Brexit will happen. Can you give the committee and Parliament some form of guarantee on how people can be protected if Parliament does not have delegated powers? Should we write a letter? Should we ask people from Westminster to come to the committee to give evidence on why we are not being given powers?

Joe FitzPatrick: It is for the committee to decide how it wants to do its business. You may rest assured that the Scottish Government will continue to press the point about protecting the powers of this Parliament.

You are right that there is still huge uncertainty about Brexit. We are discussing today arrangements that would come into effect only in the event of a no-deal Brexit. It is about ensuring that provisions are in place for the worst-case scenario, whether we reach the cliff edge on 29 March, 12 April or at some other time. Exit day is when the provisions would come into effect; they would not come into effect before then.

The Convener: Thank you. The committee will certainly consider those matters.

You said that the most recent statistics, from 2017, show that the matter affects 29 people in one direction. Do you know what the numbers are in the other direction?

Joe FitzPatrick: I am not aware of patients from EEA countries using the directive to access treatment in Scotland. As far as we are aware, the directive has never been used in that way.

The Convener: Thank you. David Stewart has a final supplementary question.

David Stewart: The subject has been partially covered, convener. I want to ask about the transitional arrangements. As we heard, the directive is rarely used in Scotland; we are not talking about the S1 form and S2 form routes. As you know, minister, if a Scottish pensioner who lives in an EEA country—for the record, that is one of the 28 EU community countries, plus Iceland, Liechtenstein and Norway—or Switzerland has prior agreement to get treatment in Scotland, there will be a 12-month period during which treatment will be provided in Scotland free of charge. Is there contingency to cope with that? I take it that the numbers will not be high, but if there were suddenly to be a surge in cases, health boards would need capacity to deal with it. Will you say a little more about the transitional arrangements?

Joe FitzPatrick: I do not understand how there would be "a surge". The approach will maintain the current position, so I do not see how the numbers would get higher than they are just now. I am sorry—maybe I did not understand the question.

David Stewart: Let me clarify. You will be familiar with the transitional arrangements. If a Scottish pensioner, for example, who lives in one of the eligible countries has had prior permission to have treatment in Scotland, it has been agreed that healthcare will be provided free by the Scottish health service during the 12-month period after exit day. That is provided for—

Joe FitzPatrick: I am sorry. Are you talking about pensioners?

David Stewart: That is provided for in the regulations.

Do you have an idea of the numbers who will use the provision over the 12-month period?

Joe FitzPatrick: I do not think that we do.

John Brunton: We do not have such numbers.

Joe FitzPatrick: The alternative would be to leave some individuals with potentially no access to health care anywhere in Europe. It is pragmatic that we take account of that in the regulations.

David Stewart: The regulations say that, if people have prior agreement, they can access free treatment in Scotland for a 12-month period. That is laid down in the regulations that we are approving today.

John Brunton: We do not know how many pensioners have come back to Scotland and we do not know how many there might be. We will monitor the position over the year. England has already done this, and Wales is considering doing so. It is likely to prove to be sensible for Scotland to follow the other countries in doing so.

David Stewart: I am sympathetic to the minister's comment that he does not expect a surge in numbers. However, if he does not know the numbers, he does not know whether there will be a surge. All I am getting at is that we need to give some understanding to health boards that there will be additional pressure on NHS resources in Scotland for a 12-month period because—

Joe FitzPatrick: I am not—

David Stewart: If you would let me finish, minister, you would understand the point that I am making.

The issue is that there is a 12-month transition period laid down in the regulations that we are being asked to agree today. If a person has prior agreement, they will have a right to get health care in Scotland for 12 months if they live in one of the countries that I mentioned. The minister says that he does not know how many people will access that. Therefore, it is difficult to know whether there will be a surge. My assumption is that there will not be a lot of pensioners who will access that, because the directive is not widely used across the EU. For good planning in the health service, surely the minister should try to find out what numbers might be involved.

Joe FitzPatrick: Your premise that it is not a huge number is probably correct. We will take the point on and check whether there is relevant information.

The Convener: Does Brian Whittle want to come in briefly?

Brian Whittle (South Scotland) (Con): I do. Good morning, panel.

The Convener: Before you make your point, I note that we will move on shortly to the debate. If it is a point, rather than a question, I suggest that you leave it until the debate.

Brian Whittle: I will leave it until the debate.

The Convener: We move to item 3, which is the formal debate on the instrument. I remind the committee that members may no longer put questions, but can make points in the debate. Officials will not take part.

Joe FitzPatrick: I move,

That the Health and Sport Committee recommends that the Cross-border Health Care (EU Exit) (Scotland) (Amendment etc.) Regulations 2019 [draft] be approved.

Brian Whittle: I will now kick off. I have listened to the questions to the minister with great interest. I declare an interest, in that my parents lived in Spain for 10 years and, while they were there, both had serious conditions that were treated in Spain and in the UK, and there was no problem. One had cancer, and one had a back operation.

We are trying to create problems here. We are politicking round the table and creating problems. As it currently stands, a person can get treatment in an EU country and, if they come back to the UK, can get treatment here as well. That happened practically and there were no barriers to it. I do not know where we are going with this or what we are trying to get out of it. It is beginning to irk me that we are creating problems that are not there.

The Convener: Thank you. Since I see no other member wishes to contribute to the debate, I invite the minister to wind up.

Joe FitzPatrick: To wrap up, Mr Whittle is correct that the system works well across Europe just now. The regulations are to put in place protections in the event of a no-deal Brexit. If we do not put those protections in place, there could be people who are currently in the process of using the directive to access treatment in another EU country who would potentially be left high and dry in the middle of that process, either just prior to their operation or just after receiving the operation and prior to receiving funding.

We have talked of a number of matters—I appreciate that the committee likes to do so—that do not relate directly to the regulations that are before us. The regulations are a pragmatic approach to deal with a no-deal Brexit. In any other scenario, they would not necessarily be required.

The Convener: The question is, that motion S5M-16442 be agreed to. Are we agreed?

Motion agreed to.

The Convener: I thank the minister very much, and I suspend the meeting for a few moments to allow him to depart

10:30

Meeting suspended.

10:32

On resuming—

National Health Service Superannuation and Pension Schemes (Scotland) (Miscellaneous Amendments) Regulations 2019 (SSI 2019/46)

The Convener: Item 4 is consideration of an instrument that is subject to negative procedure. As colleagues will recall, we considered the regulations at last week's meeting and agreed to write to the Scottish Government for further information on a number of issues. This morning, we received a letter from Kate Forbes, the Minister for Public Finance and Digital Economy, in response to our questions.

I invite comments from members.

David Stewart: You will recall, convener, that I raised this issue last week. I am concerned about the 6 per cent jump next month in the employer contribution. Many members will have received correspondence on the matter, particularly from general practitioners, who will be dramatically affected by the costs for their staff, such as receptionists. It might result in redundancies in the longer term. Some general practices might not be able to continue and the worry then is that they go back under health board control.

There are particular issues in rural areas; recruitment and retention of GPs might be affected; and there is also an issue with non-NHS employees such as those in the hospice movement. Indeed, a number of members have raised the same issue, and Children's Hospices Across Scotland has written to us to say that the change will cost another £350,000 a year, which is the equivalent of nine full-time nurses.

I have seen the letter from the minister. Obviously, these are primarily reserved issues, but these changes, coming on top of the changes to the lifetime and annual allowances, are hitting GPs and consultants. I do not think that there is anything that we can do today but accept the regulations, but it is important that I put on record my great concern, which I am sure is shared by the committee, about the effect that these changes will have, particularly on the recruitment and retention of GPs—unless, of course, there is some Barnett consequential to remedy what is going to happen.

The Convener: Indeed. The points that you have made are very important.

Sandra White: I, too, have concerns about the regulations that I have raised previously. David Stewart is correct that they will affect not just GPs but receptionists and so on. They could also affect charities, and I have great concerns about that. That issue was raised at the Education and Skills Committee and, when I checked last week, I found that the Scottish Parliament information centre was not aware of it either.

The regulations are coming in, yet a lot of people are not aware of them, and they could have dire consequences for services. This is a reserved matter, so the big worry is that the Westminster Government will not give money for consequentials. I think that it does not fall into the category of health consequentials, because it is not only the health sector that will be affected. I would like that to be clarified, as there could be dire effects on front-line services in the health sector and elsewhere.

Although I understand that we cannot stop the regulations going through today—I asked for advice on that—I wonder whether the committee is minded to follow up the concerns that some of us have raised, and perhaps to write again to the minister, Kate Forbes, for clarification about where the money will come from and whether the Scottish Government will press the UK Government for the extra funds. It is the UK Government that has raised the level of the pension contribution, so it should not be incumbent on the Scottish Government, which does not have that power, to make up the shortfall. If this is part of a trend, it is a worrying one; certainly, it is one of many that have come forward.

Emma Harper: I agree with David Stewart and Sandra White on the aspect regarding people working in GP practices, whether they are doctors, nurses, receptionists or admin staff. I represent a rural region that already has GP recruitment challenges. I want to ensure that we monitor this issue and make sure that the changes have no negative impacts.

The Convener: It is important to say a couple of things to Sandra White. It is open to us to stop the regulations today, but if we did so, it would be by annulling them. Therefore, they would have to go to the chamber this week, because they are due to come into force on 1 April. They would have to be dealt with by the Parliament in time to stop that. That option is available to us.

On the funding question, I remind colleagues that Kate Forbes was clear in her letter, which said:

> "Failure to fully fund these costs will have a significant and detrimental impact on the delivery of essential front line services in Scotland."

It is important to note that the Scottish Government continues to engage with the Treasury on that issue. The letter continues:

> "the Scottish Government will take the appropriate steps to disperse the additional funding",

if that is received from the Treasury, and

"if there is a shortfall in the funding from the UK Government",

the Scottish Government will

"consider how that shortfall will be met."

That seems to imply that the shortfall will be met, but it would be worth our while to write back to Kate Forbes, even if we agree to approve the regulations, and ask for confirmation that the intention is that, come what may, the shortfall will be met and there will be no impact on general practices, hospices and other organisations that members have mentioned. Are members minded to do that?

Members *indicated agreement.*

The Convener: Does the committee agree to make no recommendations on the regulations?

Members *indicated agreement.*

Scrutiny of NHS Boards (NHS Lanarkshire)

10:38

The Convener: Item 5 is an evidence session with NHS Lanarkshire, which is part of a series of evidence sessions that the committee is holding with territorial health boards. I welcome to the committee Neena Mahal, chair, Calum Campbell, chief executive, Dr Jane Burns, medical director, and Heather Knox, deputy chief executive and director of acute services, NHS Lanarkshire; Dr Linda Findlay, medical director, South Lanarkshire health and social care partnership; and Ross McGuffie, interim chief officer, North Lanarkshire health and social care partnership. I thank you for the written evidence that you have submitted in advance of today's meeting.

One of the first areas for the committee to consider in its scrutiny of boards is the fundamental issue of financial balance and the ability of boards to achieve many objectives within the envelope that is available to them. We noted in your financial plan and Audit Scotland's annual audit that you anticipated a £26 million funding gap for the current year, which has nearly finished, but you have now achieved a break-even with some recurrent efficiencies required. It will be useful to have a brief summary about that and an explanation of what you have done to close the funding gap, given that it was significant only a few months ago.

Neena Mahal (NHS Lanarkshire): I thank the committee for giving us the opportunity to present evidence today. I will ask the chief executive to give more specific details about the financial balance, but you are correct to say that we aim to achieve financial balance at the end of this year. We have done that for a number of years, and it has been very challenging—we will talk about the challenges as we go forward.

We have been able to close the gap because the board has tight management of our financial situation, with good oversight and scrutiny from the board right down to individual teams. The finance team is well known throughout the organisation and we have a very joined-up approach. We engage with our clinicians and staff and discuss our savings through the area partnership forum and the area clinical forum.

Our approach to considering savings is very structured; the board does a lot of horizon scanning and we can identify risks clearly and early on. However, we have to have a balance between financial performance and not compromising on quality. Our approach in NHS Lanarkshire has been helpful to ensure that it is at

the forefront of everybody's minds but without compromising on maintaining performance and quality.

For the specifics, I will turn to our chief executive, who can talk about our challenges going forward.

Calum Campbell (NHS Lanarkshire): First, I will speak about our approach in NHS Lanarkshire, which Neena Mahal, our chair, has touched on. I cannot speak for other boards, but we have a very gifted director of finance and finance team. We take a risk-based approach; every scheme that comes forward has been risk assessed, so we do not automatically presume that it will be 100 per cent successful. We work through that with general managers and clinicians.

Secondly, we challenge any cost pressures—we do not just accept that the automatic solution to a cost pressure is that we have to fund it. A practical example is the challenges that our mortuary faced. We are getting larger as a nation and so we require additional bariatric capacity in our mortuary. The estates team pulled together a very good business case, which came to £250,000. If it had come across your desk, you would have thought that it was well thought through and logical. However, because we work as a team, the head of procurement looked into buying bespoke units for mortuaries for the larger individual. In effect, that £250,000 cost pressure became a £70,000 cost pressure. We try to look for innovative solutions.

I will also touch on prescribing. In the past, we were not the best at that, so we have had a prescribing quality efficiency programme, which I am sure will come up later on in the discussion. We had the second highest cost per head of weighted population in Scotland, but now we are below average. That was done through using prescribing quality efficiency; it was not just cost savings, because there has been an emphasis on quality.

To get the £26 million funding gap down, we have made savings in prescribing and procurement. We have reduced our agency and drug expenditure, but the reality is that we have worked through more than 100 schemes to achieve that. We will go into next year with some non-recurring pressures still requiring to be addressed.

The Convener: Thank you very much. Clearly, as a well-run ship in financial management terms, you will have seen announcements by the Scottish Government about it providing brokerage to other boards and writing off brokerage, and boards saying that they may need future brokerage. What incentive does your board have to maintain a prudent and proactive approach to financial management?

10:45

Neena Mahal: It is extremely important to recognise that this is all about providing safe care to our patients and that that must be at the forefront of everybody's minds, but the situation is challenging, given that our board has not received any brokerage or a bailout. It will be a challenge to keep our staff incentivised; it might be helpful if the chief executive explained some of those challenges, but we will endeavour to keep the tight ship that you have mentioned.

For us, the key thing is that, from the board right down to individuals, we work very much as a team, we are absolutely clear about our direction of travel, and we have a strategic direction through our healthcare strategy and our close work with the IJBs. We know where we want to go and what we want to deliver, but it will be very challenging, given that we are not being—to use a word—rewarded for our performance.

Calum Campbell: With any allocation formula, there are opportunities for improvement, but it is important to have a formula in the first place. Just to set some context, I point out that, per head of population, NHS Lanarkshire is one of the lowest general medical services-funded boards in Scotland. We also have two private finance initiative hospitals; when they were built, there was no capital available, and that pressure now amounts to £60 million a year.

We have good corporate buy-in, because the board wants to stay in control and does not want any external influence on how we go about things. However, in answer to what I think was a fair question, I think that there needs to be fairness and equity because, fundamentally, the board is there to do the best that it can for the population that it serves. The population of Lanarkshire is deprived in many areas, and we must ensure that we get a fair allocation for them.

The Convener: Perhaps I can put my question from a different perspective. If you know that, even within your current financial constraints, you can still deliver services to what is a large and, as you have said, relatively disadvantaged population and you see that other boards are not able to do the same, is there any mechanism that you can use to share your approach to financial management with those boards across NHS Scotland?

Calum Campbell: Certainly. My director of finance frequently meets the other directors of finance in NHS Scotland, and the west of Scotland directors of finance have similar meetings, as do I and my other executive colleagues. One of my favourite sayings is that I have never had an

innovative idea in my life, but I specialise in plagiarism. We spend a lot of time looking at what others have done, and there is no shame in that; indeed, stealing shamelessly what others have done in order to be successful is the highest compliment that can be given.

A good example of that is the fact that we were one of the last boards to implement ScriptSwitch, but it has delivered for us as a mechanism for making savings in prescribing. We try to share what we do with boards, but equally, we learn from them.

The Convener: One challenge being faced by all boards is the increasing cost of medicines. Has ScriptSwitch enabled you to address that issue directly, and will it be adequate in keeping those costs under control?

Calum Campbell: I will start and then perhaps ask my medical director to say a few words.

One of the biggest cost pressures that we will face comes from acute drugs. Although we will get a 2.6 per cent uplift this year, our acute drug expenditure is going to increase by around 16 per cent; indeed, over the past five years, it has grown by around 60 per cent. It is a massive pressure and, to be honest, if we do not do something about it, we will not be able to sustain balance.

I do not know whether the medical director would like to elaborate.

Dr Jane Burns (NHS Lanarkshire): I am happy to do so. As Mr Campbell has said, one of the key responses to this issue across the whole organisation is the relentless focus on the quality of care that we provide. With that focus, we have clinical engagement in and support for driving all of our initiatives. As you will know, safe care costs less, because we do not have to deal with the same complications in patient care. That is what motivates our clinical teams, and it will produce a sustainable methodology for us, but there are some really significant and outstanding challenges that we still have to face.

In the past 12 months, we have taken a quality approach to reducing variation. We have standardised our approach to antimicrobial prescribing, in line with best-practice stewardship. We have reviewed high-risk areas of prescribing and, as has been said, we have reduced the cost per patient to below the national average for the weighted cost per patient—our figure is now among the best in class. The change to ScriptSwitch gives us the opportunity to continue to offset rises in primary care prescribing that we predict for the forthcoming year, but the significant challenges will be in the acute division.

In the year 2018-19, which is about to end, the acute division is predicted to have a marginal overspend of just under 1 per cent of its £51.23 million prescribing budget. That is despite a 6 per cent increase in costs, which is largely because of increases in the costs of treatments for lung cancer, myeloma and prostate cancer. We have managed the situation through a significant number of initiatives.

We have switched to biosimilar agents, with a quality approach that uses nurse practitioners to support the change from one agent to another more cost-effective agent. We have also looked at reducing, and in some cases stopping, patients' medication when they have been on a treatment for a long time. We have recruited into research studies some patients who are on very high-cost medicines, which offsets the cost to the NHS of paying for those medicines. We have increased the number of patients who are being managed by the hospital at home project, whereby medicine is delivered to the patient's home, and that has produced an in-year saving of £2 million.

In addition, we have had a range of initiatives across our acute hospital sites to reduce variation by looking at things such as patients bringing in their own medication, rather than us reproviding extra dispensed medicines. We have looked at the consistency of clinical practice and at switching from intravenous medicines to oral medicines, which also have the benefit of reducing healthcare associated infections. Our hospital pharmacists have brought rigour to looking at the costs of individual medicines, which can fluctuate throughout the year—that depends on the supplier.

As our chief executive said, we expect a 16.6 per cent increase in our acute drugs costs next year. Of that, 54 per cent is expected to be for new cancer drugs that the Scottish Medicines Consortium has approved. However, a concern is that about 22 per cent of the increase is from medicines that are going through the new peer-approved clinical system tier 2 process.

For drugs that are authorised to go through that process and for those that we have been advised to put through it, although they do not have approval from the Scottish Medicines Consortium, my concern is that the process is a much more permissive way of prescribing. Previously, we had senior clinical professional input, from a more broadly based panel, to the decision making about very high-cost medicines, in order to support the clinicians making the recommendations and to ensure that they did not defer to undue bias towards the patient whom they were personally treating. Often, it is difficult to tell a patient that there is no longer something new to offer that will benefit them.

I liken that governance process to the sort of governance process that is used in

multidisciplinary team meetings—if a patient is scheduled to have cancer surgery, for example, a team-based decision is made to discuss the potentially effective treatments that are available for patients, and the patient is given an opportunity to discuss that with their treating clinicians on a shared decision-making basis. However, the process that we now have in place for medicines management bypasses that governance and that team-based approach, which will give us a significant cost pressure in the coming year.

Brian Whittle: You touched on an area that interests me greatly—the increase in the prescribing of medicines. Everybody agrees that prevention is better than cure and that we are trying to move towards the preventative health agenda. Does your budget allow you to start working towards the early intervention that might help to cut the treatment and prescription costs that you have talked about?

Dr Burns: We will roll out additional measures as new initiatives and extended initiatives. We have just started to develop a process for addressing polypharmacy—that is, the number of patients who are on a large number of medicines, who have often been on those medicines for many years, with the result that they have ceased to have any particular benefit—in fact, they might contribute to harm, because of potential interactions. It is sometimes the case that, after taking a medicine for a period of time—a decade, perhaps—the benefit to the patient might no longer be of the same magnitude. We are starting to look at how we can manage that agenda, in particular.

David Stewart: I have a quick question on the same point before I move on to my substantive questions.

A number of members of the committee are very interested in diabetes: Brian Whittle, Emma Harper and I co-chair the cross-party group on diabetes. I am very enthusiastic about preventative spend. As you will know, around 10 per cent of spend goes on dealing with the complications of diabetes.

On technology, I have been very impressed with some of the continuous glucose monitoring devices, such as FreeStyle Libre. Dexcom—whose facility I visited yesterday—has the new G6 continuous glucose monitoring device, which is absolutely the state of the art; I do not have shares in the company, I hasten to add. I raise the issue because we know that such devices can save money, but the route to obtaining them is complicated. As they are not medicines, technology approvals are required. Some boards—including the board in my neck of the woods, up north—have been a bit slow to act, before final approval has been received.

Sometimes it is necessary to spend to save money, and that is vital with diabetes. In Sweden, for example, 85 per cent of type 1 diabetes sufferers are on a form of continuous glucose monitoring, which is a phenomenal rate. My general point is that money can be saved through investment in technology. Continuous glucose monitoring devices are very effective. What can your board do to promote not just pumps, which are highly effective, but continuous glucose monitoring devices, which come at the stage before that?

Dr Burns: I completely agree. The preventative agenda is absolutely essential when it comes to diabetes care. That area is well worthy of an invest-to-save approach, because although the population benefits might be 10 or 20 years down the line, there will be a significant reduction in longer-term complications, which are one of the main healthcare challenges that we face.

Our diabetes team, which works through a managed clinical network, supports patients to move on to appropriate types of glucose monitoring as and when they require that. It does that in an evidence-based way, but one of the greatest barriers can be not being able to bring patients in to educate them in how to use the technology effectively.

David Stewart: I will get a row from the convener if I do not move on, but I have another quick question on the same subject.

In the past, having targets for pumps has worked. Before that, as you know, there were significant problems. Yesterday, I had a meeting with Dexcom. My theory is that having a target for continuous glucose monitoring will probably work, because that is what boards respond to—such matters are mentioned in chief executive letters and so on.

I am not expecting a political answer today, but could your board have a think about whether that approach would work?

The Convener: That is perhaps a question for the chair of the board.

Neena Mahal: We are keen to look at all measures that will improve the health of the population, so it would be inappropriate to comment. However, we will consider that suggestion.

We must also look at the upstream work that we can do—I am talking about preventative measures to stop people getting diabetes in the first place. Early interventions when people are diagnosed with diabetes are important, but we need to ask what else we can do when it comes to investment. We need to work out which investments are

beneficial in stopping diabetes at a very early stage.

David Stewart: Thank you very much.

I had better move on to my main questions, which are about staffing and sickness. Could you explain the reasons for the long-standing high sickness absence rates? I think that an amber warning was given on that issue in the Government statistics.

Neena Mahal: Our sickness absence rate is roughly 6 per cent. We have several initiatives to try to improve that. There is very close management in supporting people to come back to work, where they can. I will ask our chief executive to comment on some of the specific initiatives and issues around the long-term sickness figures.

11:00

Calum Campbell: You are correct that we have been challenged by our sickness absence rate. As well as being chief executive of NHS Lanarkshire, I co-chair STAC. The committee will be aware that part of this year's pay settlement is a revised sickness absence scheme as part of the once-for-Scotland approach and there are key triggers within that.

The Convener: Can you explain what STAC is?

Calum Campbell: STAC is the Scottish terms and conditions group. I am the employer representative on the group and we also have staff-side colleagues on it. There have been various workstreams in the pay settlement this year, one of which is focused on sickness absence. There is a revised once-for-Scotland policy, which will have key triggers to ensure that we standardise and drive the absence figure down. We try to use our occupational health service as best we can, but it is a concern that that rate is as high as it currently is.

David Stewart: Members have had different life experiences and some of us will have been involved in recruitment. I always consider a company's statistics on turnover, sickness absence and retention, because those are sometimes signs of a deeper problem.

You have some vacancy issues, particularly in medical and nursing roles. Would you like to say a bit more about that and what you are doing to tackle those?

Neena Mahal: I will ask our medical director to talk about the medical vacancies.

Dr Burns: Our medical workforce stretches across primary and secondary care. I will not go into detail about primary care medical staffing. I am sure that Dr Findlay could talk about that workforce in detail, if that was required. Suffice it to say that, like most health boards, we are facing some real challenges in the recruitment and retention of general practitioners. We have a sustainability plan in relation to that, which we are working through with our colleagues in the partnerships.

We are making every endeavour to improve recruitment and retention. We had a meeting relatively recently with NHS Education Scotland to try to increase the number of training placements in general practice and the number of training practices and authorised trainers, to try to boost those numbers. We know that our workforce is sustainable when it is comprised of those who live locally, who want to continue to stay locally. The General Medical Council has good evidence on that being a significant factor in career choices for young doctors in training.

In secondary care, we have had many initiatives. We currently have a shortfall in our workforce of around 15 to 16 per cent, which is significantly above the national average. It varies by specialty and I can give the committee details on that if members wish me to do so. The general actions that we have considered to address that have been whole system. For example, we have looked at how we can widen access to medical training. We have developed relationships with local schools. We run career information services for local school pupils to allow them to come and learn about not just medical careers, but all careers in the medical healthcare professions. We look to provide work experience for school pupils and specific work experience for school pupils studying for their highers who want to enter the medical profession. We give them some tailored experience and support for their application for medical school.

At undergraduate level, we have improved the level and quality of training that we offer for medical students coming out to our hospitals and GP practices. Having a positive experience as a medical student is likely to boost recruitment and retention thereafter. We have received significant national plaudits for the quality of our undergraduate training across many of our specialities.

We develop leadership roles in doctors in training and postgraduate training. We have also substantially improved the quality of training for every single specialty that we have in NHS Lanarkshire. We have received a significant number of plaudits. In a recent poll of graduates, University hospital Wishaw was voted the best hospital for training.

Through the colleges, we focus on international recruitment of doctors in training, too, and we use that route for the recruitment of consultants in very

hard-pressed specialities, such as radiology and mental health.

We are looking at development for consultants so that they can expand their portfolios into research and development, medical leadership and service redesign and so that we can make those roles more attractive. We have looked at the whole system with regard to what will improve our ability to recruit and retain, but as a board that sits between the large medical school or university boards and despite our strategic partnerships with other universities, we still find it a challenge to compete with larger teams where out-of-hours work is less frequent.

David Stewart: That all seems very sensible.

I know that other colleagues want to come in but, finally, can you say a little bit about your strategy for attracting non-EU staff? None of us can read the entrails of what is happening at Westminster, but on the basis that we are leaving, I presume that a focus on non-EU medical staff is important.

You might not have the figures in front of you, but can you also say something about the NHS surcharge, which, as you will know, employers normally have to pay for non-EU staff earning over £30,000 and which the UK has doubled? What is your strategy for staff from, say, India, Pakistan and so on?

Dr Burns: As far as the medical graduate route is concerned, there are two different mechanisms, both of which we utilise. The first is the Scottish Government-sponsored international medical training fellowship, which is for doctors who are coming up to the end of their formal training and who are, therefore, just short of consultant level. We have accessed that to advertise for positions in what, for us, are two hard-pressed areas—emergency and general medicine—but I have to say that we have not had tremendous success. The expectations of people coming to work at that level in their training is different from the experience that we can offer, because the service gap that we have is not quite at the same level.

We have had more success with the second mechanism, which is the international medical training initiative that is sponsored by the royal colleges. Indeed, many of our consultants have come through that themselves or have strong links with it, and a number of our doctors who are graduates from India or Pakistan or who have family roots there have used their contacts to identify individuals who can be sponsored by the royal colleges to come and work with us as international medical graduates. They are usually at the middle level, which is exactly where our service gap is and where we also have strength in training.

The Convener: A number of colleagues have questions in this area. I will start with George Adam.

George Adam (Paisley) (SNP): According to Dr Burns, one of the challenges that you face with recruitment is the fact that you are in between Glasgow and Edinburgh. Will you elaborate on that? What particular challenges do you face in recruiting and retaining staff?

Neena Mahal: Obviously, we have the medical schools in Glasgow and Edinburgh, which Dr Burns can talk about, but we have put in place a number of initiatives to ensure that we are an employer of choice and that, even though Lanarkshire does not have a medical school, we can attract people to come and work for us. We are working in very close partnership with a number of higher education institutions on innovative ways of attracting people, because as Dr Burns has said, those who have worked and trained in Lanarkshire are more likely to take up a permanent role there. It is all about getting into people's psyche—if I can put it that way—the idea that Lanarkshire is a good place to work.

In addition to those initiatives with higher education institutions, we have some initiatives at an earlier stage that are about showing school leavers what Lanarkshire is like with a view to getting them to contemplate the area as a place where they could work. Dr Burns might want to elaborate on the specific issues that arise from the situation regarding medical schools.

Dr Burns: There are a number of areas to highlight. First, geography does not tend to be a huge issue, because most people at consultant level are happy to travel across the central belt. We are therefore able to recruit; however, we sometimes have difficulties with retention. That is usually because of what I would call the preferential work-life balance in the larger teaching hospitals that provide the tertiary services, which involves less frequent out-of-hours work. In addition, because tertiary services are offered there, the more senior doctors in training have to go through rotations in those clinical departments in order to get all the components that are required by the curriculum that is set by the General Medical Council for their full training. If they miss those opportunities, they have to go back and do them again.

That cohort of doctors rotates out to Lanarkshire for part of their training. However, those posts are in general medicine and general surgery, and there is less need for them to be filled by trainees. There is therefore no imperative for the trainee to come back and repeat a training allocation in a district general hospital if that is missed, because usually by the time that they get to the end of their

training, they can manage to achieve all the competencies.

That slot in the duration of a seven-year training programme is often when a doctor in training will choose to take time out of programme, as it is described. They might choose to start or complete a family, and maternity and paternity leave affect our ability to show those doctors in training the benefits of working in Lanarkshire; that is how I would describe it. That is a real difficulty for us, so we constantly tell NHS Education for Scotland that we must have those posts filled so that we can compete when it comes to recruitment and retention of staff and can give individual doctors the experience of working in Lanarkshire so that they will come and work with us. That is something that we try to tackle.

We have also created different opportunities for doctors in training who, when they complete their foundation years, do not want to go straight into a lengthy seven-year training programme. The latest General Medical Council figures showed that only about 20 per cent of doctors went straight on to those training programmes. We have offered different opportunities that allow doctors in the third year of their training to go into medical education, simulation training, leadership roles, quality improvement roles and so on. Our giving them different opportunities helps them to stay in Scotland.

George Adam: I want to ask about a specific issue. I should probably declare an interest, because I am the convener of the cross-party group on multiple sclerosis and my wife has MS. A year or two ago, there was a campaign because there were no MS nurses in NHS Lanarkshire. The previous specialist nurse had left because she believed that she was overworked as she was dealing with more than the recommended 315 patients per MS nurse. I believe that NHS Lanarkshire now has coverage by 2.5 MS nurses available, which—if you ask me—means that it was a successful campaign.

At the end of the day, the question is about the future. A review is being carried out of services for people who have MS in Lanarkshire. In which direction are we going? What are we doing in Lanarkshire for people with MS? How are we making sure that what happened previously does not happen again?

Dr Burns: I am happy to pick that up as best I can on behalf of my nursing colleagues. The future for support services for patients who have MS lies in nurse practitioners providing services in the community and acting as a liaison service between patients and the consultant neurologists.

Neurology is a good example of a tertiary level service that is provided by NHS Greater Glasgow and Clyde. Although we have created Lanarkshire-based consultant neurologist posts, we have failed to retain individual consultants because they are more attracted to the tertiary centres where there is a high level of research in that specialism. We will never be able to compete numerically, because we will only ever have two or three consultant neurologists at most. It is quite difficult to sustain that workforce, which makes it important that other healthcare professionals, such as advanced nurse practitioners, help to support the service.

The Convener: I remind colleagues that time marches on, so I ask for brief questions and answers, if possible.

11:15

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, panel. I will try to be brief.

In our scrutiny of other boards and wings of the NHS, we have detected that, when recruitment and retention are an issue, there is a corollary for staff morale, whereby staff's confidence that they are being heard and their faith in the systems through which they can raise concerns are affected. Will you take us through your whistleblowing practices and the strata in the health board that allow staff not just to complain or raise concerns, but to contribute ideas and expertise to the growth and development of the organisation?

Neena Mahal: I will start, but other colleagues can contribute.

From the board's perspective, it is extremely important that we are connected to front-line staff and that we hear from them about issues and challenges, as well as about the good things that need to be celebrated. For example, all board members participate in leadership patient-safety walk rounds, which give us an opportunity to see staff and to focus on understanding their concerns.

In addition, we have the full whistleblowing policy and practice, which our chief executive can talk about. We have done work on psychological safety. We have done a culture of safety survey with staff, which we started with our nurses, midwives and allied health professionals, and which we are extending to other cohorts. That gives staff a safe space in which to voice their concerns and to tell us how they feel about their ability to raise concerns—formally or informally—and what we can do to shape that culture. That is really important. We can have all the policies and practices that we want, but we must have an open culture that involves dialogue and the ability to reach out to staff in various ways. Calum Campbell might want to expand on those initiatives.

Calum Campbell: Neena Mahal touched on one of the key differences. We carry out psychological safety questionnaires; we started with nursing staff and have progressed beyond them. We ask people whether they feel confident and safe enough to speak out. We want especially to be told if there are missed episodes of care. The chair touched on the fact that we do leadership walk rounds. We also do patient-safety walk rounds. Walking round the place gives people the chance to see us and to raise issues. If people want to send an anonymous email to the director of human resources to raise issues, that mechanism is also in place.

Emma Harper: Good morning, everybody. I am interested in improving waiting times. The quarter 2 report that was submitted to the board showed that 11 key performance indicators were red or amber, including on 12-weeks for out-patient appointments, the 18-week referral-to-treatment period, child and adolescent mental health services, access to psychological therapies, advance booking to primary care and the detect cancer early programme. I am aware that the Scottish Government has released £146 million to help to address waiting times. Have you heard how much of that money NHS Lanarkshire will get? What do you propose to do with it?

Neena Mahal: I will split the response to your question into two parts. Heather Knox will talk about waiting times in the acute sector, while Mr McGuffie will focus on the CAMHS performance.

Heather Knox (NHS Lanarkshire): We have areas in which our performance is very good. In particular, we are very proud of our cancer performance; within the acute team, we really focus on that. We have also made great progress in our hospital standardised mortality ratio—HSMR—performance. If you wish, Jane Burns can tell you more about that.

As you rightly point out, there are areas in which we are working hard to improve our performance. I am pleased to report that, in recent months, we have seen a significant improvement in NHS Lanarkshire's performance against the out-patient 12-week target, which is one of the targets that Emma Harper mentioned. Back in October, we had about 5,500 people waiting more than 12 weeks for an out-patient clinic attendance. As of yesterday, we had managed to bring that figure down to fewer than 3,000 people. I hope that the committee will agree that that is a big improvement in quite a short period.

For the treatment time guarantee patients—patients who are waiting for an operation—the figure was more than 2,000 back in October and is now down to 1,430. On that performance measure, we are the most improved mainland board in Scotland.

We also benchmark well across Scotland. The Lanarkshire population makes up about 12 per cent of the Scottish population. If we accept that about 2 per cent of our patients will be treated in Glasgow, we would expect our share of the waits to be about 10 per cent. Back in 2015 or 2016, we had about 10 per cent of the overall number of patients in Scotland who were waiting more than 12 weeks. Our share of the out-patient waits has now fallen to its lowest in the past four years—we now have only 3.8 per cent of those waits. I am really proud of the progress that we have made in recent months. I know that our performance on that is still showing as amber in the report and that there is more that we can do, but I am pleased with progress. The whole team has done a lot of work to deliver that.

We are keen to sustain that improved performance. To do that, we need to put in place redesign programmes. It is not just a case of having more and more patients being treated in the hospital sector; we need to look at the demand and the pathways from primary care into secondary care to see whether we can do some change management in that area. For example, a person who has coeliac disease will now be seen by a dietician, and might be seen at their GP's practice rather than in hospital. That takes the burden off consultants and frees them up to see other patients.

We have also put in place a lot of virtual clinics. We have learned from other sectors. For example, banking has effected a change from face-to-face services to telephone and virtual services—it has flipped the service on its head. That is what we need to do for many of our out-patient consultations. We are moving away from the traditional "We'll see you in our clinic when we have the paperwork and it suits us" approach. We can do a lot more virtually; GPs are doing a lot of such work already. We have set up virtual clinics in several specialties, whereby the consultants just look at the patient notes—they do not need to see the patient, but can phone them if they need to. We are seeing a big improvement in the number of patients whom we have to bring up to hospital as a result of that intervention.

We are doing a lot of improvement work to change the demand on our services. I would be happy to talk for longer, if I have not answered Emma Harper's question.

The Convener: We will hear from Ross McGuffie and then perhaps come back to you.

Ross McGuffie (NHS Lanarkshire): We have a really strong performance culture. For example, the health and social care partnerships have quarterly performance reviews with each of the locality teams, and there are quarterly reviews in which the chief executive reviews our

performance. In North Lanarkshire, both the chief executive of the council and the chief executive of the health board scrutinise performance. We have got a very strong culture.

Historically, we have been one of the better-performing boards in respect of CAMHS. However, in recent years, the service has come under increasing pressure: demand for the service has doubled since 2012 and, in the past year alone, we have seen a 60 per cent increase in urgent referrals, which has a knock-on impact on the wider waiting list. The direction of travel in relation to funding has been positive. We had a number of temporary funded allocations that have become permanent. We have also moved some staff from temporary contracts to permanent ones ahead of those changes in an effort to bring more stability to the service.

Staff demographics is a challenge for us. The workforce is predominantly female and a significant proportion is at the younger end. At the moment, out of a service of 113 whole-time equivalent staff, we have 14 who are on maternity leave or are just about to go on maternity leave. That means that more than 10 per cent of the service is on maternity leave at any one time.

As we have picked up in answer to previous questions, recruitment within CAMHS is very competitive in the central belt, so recruiting and retaining staff is a challenge for us. We undertook a deep-dive exercise, which was led by our medical director in the partnership. That has come up with several actions that are to be taken forward either immediately or across 2019-20. We have identified additional peripatetic posts to cover areas in which there is significant staff absence through maternity leave and so on. We have reviewed the number of team bases and we are looking to change that number to improve the resilience of the service.

Significant work is being done on the neurodevelopmental pathway. That is one of the actions of the national task force work. There has been a lot of national interest in the approach that we are taking, which will result in the development of a multidisciplinary team. The North Lanarkshire service, which will start in May 2019, will result in CAMHS, paediatrics, speech and language therapy and so on coming together in one integrated team to provide a more consistent service for people with neurodevelopmental conditions.

The other key component for CAMHS is early intervention. The national drive through the task force is welcome in that regard. We will do a lot of work through the two children's services partnerships, because it is critical to have earlier intervention in place in CAMHS so that we can do our best to provide much earlier support.

Emma Harper: I thank everyone for their input. Everybody is doing a lot of work to transform care, including by getting people to access primary care rather than secondary care, getting people out of hospital and undertaking discharge planning. There is a lot of good work going on.

Calum Campbell talked about plagiarising the work of, or getting good ideas from, other health boards. Is what other health boards are doing to address their waiting times being looked at? Is best practice being shared?

Calum Campbell: Yes. Mrs Knox summarised our performance and a lot of that is as a result of plagiarism. Last week, the review of our orthopaedic services took place, and representatives from several other boards gave feedback—generally, it was positive, and some good suggestions came out of it.

One of the challenges was that we could go further with our virtual reviews. We are probably duplicating work because we operate on three different sites; we were asked why we did not make those three virtual centres into one. There was a consultant from Glasgow and one from the Borders at that review. We challenge ourselves that way.

We are now a university board with Glasgow Caledonian University and the University of the West of Scotland. We have also started to work with the University of Strathclyde. We have recognised that we cannot continue with the current models of care, given our demographics. The fundamental challenge that we are presenting Strathclyde university with is how we can address health inequalities and match that to our workforce. We have about 10,800 whole-time equivalent staff, but despite the demographics, that number will not continue to rise. If the number of staff is fixed at around 10,800, what models of care will be required in the future if the demand on the service goes up? We are involved in a close collaboration with Strathclyde university in an effort to answer that question and ensure that we have appropriate workforce planning.

Miles Briggs (Lothian) (Con): I want to go back to the issue of preventative health. Looking at some of the national trends, NHS Lanarkshire continues to have the highest prevalence of all the health boards of smoking in its population—30 per cent of the adult population smokes and 19.2 per cent of pregnant women report that they smoke. Can you touch on smoking-cessation programmes and some of the innovative approaches that the health board has taken to date? I know that Lanarkshire engaged with the pilot project on paying people to quit. Do you have any feedback on that? How will you address that problem, which affects a high number of adults in Lanarkshire?

Dr Linda Findlay (NHS Lanarkshire): In 2017-18, Lanarkshire's target was to achieve 1,220 12-week quits in the 40 per cent most-deprived areas. Our final position was 1,273 quits, which was above target. Lanarkshire has performed at 90 per cent against the Scottish Government target—it was the third highest among all health boards. We have also exceeded overall Scottish performance by 9 per cent. Alongside that, the 12-week quit rate for 2017-18 in the most deprived areas in Lanarkshire is 2 per cent higher than the Scottish rate. Overall, we achieved 2,361 quits by March 2018.

More widely, we recently developed the "Smoke-free Lanarkshire—for you, for children, forever" tobacco control strategy, which provides Lanarkshire with a clear action plan that is in line with the Scottish Government's action plan. The vision for our strategy is to create a society for children that is smoke free and in which adults are positive anti-tobacco role models, whether they are smokers or not—even if they cannot quit themselves, they should promote to our children a "no tobacco use" approach.

The key aims of our strategy are to protect children's health, tackle inequalities and reduce the prevalence of smoking in Lanarkshire from 21.8 per cent to 11 per cent by 2022. We look forward to reporting that trajectory in the future.

11:30

Miles Briggs: The high number of pregnant women in Lanarkshire who report that they smoke is of major concern. I already mentioned the pilot projects. Are you looking to do any other work on that? What success have you had in your work with pregnant smokers?

Dr Findlay: Our family nurse partnership programme, which works with people with health inequalities, certainly works closely with young mums on smoking cessation. I would need to go away and look for more information on that.

Alex Cole-Hamilton: Delayed discharge is a problem around Scotland and we come up against it when we examine any territorial health board. In the scenario—with which many members will be familiar—of our constituents being in hospital for far longer than they need to be, for want of adequate social care provision, what is the decision-making process? Who can knock together the heads of social care and primary care providers in order to make that happen?

Neena Mahal: I will ask Mr McGuffie to talk about the delayed discharge process. We knock everyone's heads together to make sure that the process works, because it is important that we get people out of hospital as soon as they are ready to go home.

Ross McGuffie: That is a vital priority for us, as a partnership. We have approached the issue on a whole-system basis, so we have an unscheduled care and delayed discharge improvement board, which covers the North Lanarkshire and South Lanarkshire partnerships and the acute sector. It is the planning vehicle for all unscheduled care and delayed discharge work in the partnership.

A range of work has been undertaken. The headline figures are that, over the past year, there has been a 12 per cent reduction in the number of delayed discharge bed days and an 18 per cent reduction in the number of code 9 bed days, so there has been a move on that.

On the specifics of what we have done, the North Lanarkshire and South Lanarkshire partnerships both have a home support strategy and new models of home support, which focus on much more reablement, including rapid response reablement, rather than run-of-the-mill packages. The impact of that being rolled out is the start of a significant reduction for both partnerships in the number of home-support delays of more than three bed days. The ultimate positive is that rapid response reablement has a much better impact on individual patients in the long run, because we maximise their independence at that point. We hope that that will reduce the overall demand for home support in the longer term.

Daily conference calls take place in the partnership to co-ordinate complex and significant cases. Within the two health and social care partnerships, conference calls do the same across health and social care to ensure that we have sight of every complex case in the hospitals and know exactly how best to move cases forward.

We have done a piece of work on the national protocol on code 9 patients, which has had a significant impact. Twelve months ago, we would have been sitting with figures in the mid-teens for the number of delays of more than 100 bed days for individuals who were going through the guardianship process. The national protocol says that the process should take about 13 weeks, which is 91 bed days. Since doing our bit of work on that, which included identifying a number of escalation points for when things get blocked, we now—as of last week—have only four delays of more than 100 bed days in the three acute sites in Lanarkshire. That is a big improvement.

We are also taking forward a tested change for guardianship applications, and the NHS now spot purchases care-home beds so that individuals are put into an environment that is much more homely to live in during the process, and in which they are supported by appropriate medical and mental health officer cover.

In acute wards, there has been work on estimated dates of discharge. We are trying our best to do that collaboratively, so that social work is involved in the discussions much earlier.

Reviews of intermediate care provision have also been undertaken in both the north and the south. It is a critical issue, and we have started to get real traction from looking at off-site beds and step-down capacity. We are trying our best to have more of a rehab and reablement focus in those sites, because that will not only allow throughput to a much more positive destination and back into the community, but will provide the step-down capacity that we require to support people who come out of acute care.

Another recent development is the roll-out of integrated teams. In North Lanarkshire, we have integrated our rehab teams, which required our taking some physio hours from the acute sites and the community assessment and rehab service—which was acute based, too—and disaggregating that into the localities, as well as turning domiciliary, physiotherapy, occupational therapy and social work occupational therapy into integrated teams. South Lanarkshire has taken a similar approach in its integrated community support teams.

That has allowed us to create a rapid response vehicle. Over the past three weeks in North Lanarkshire, we have supported 20 early discharges to people's homes. In other words, we took people out of the previous process, in which people were required to wait on site for OT physio assessment, and supported them at home instead with a rapid wraparound service and rapid access to equipment on the day. That allows assessments to be undertaken in the community.

The big benefit of that approach can be seen not just in the number of delayed-discharge bed days, but in the destinations of individuals. If we can get people home much earlier, they deteriorate much less than they would if they were sitting in the hospital, and the assessment is likely to be more accurate in maximising the opportunity for them to remain in their own homes instead of ending up in institutional care.

Calum Campbell: To provide some clarification and set the context, I will ask Ms Knox to say a wee bit about hospital at home. I also point out that the reduction in delayed discharges in North Lanarkshire and South Lanarkshire that Mr McGuffie has referred to has happened because of the strong partnership involving the health board, both councils and the IJBs. However, we also need to recognise that our emergency admissions have gone up and the length of stay has gone down. We have already touched on the fact that we are looking after a large deprived population. The system is under pressure, but its performance is good.

Hospital at home has been a real bonus for us. Perhaps Heather Knox can say a few words about that.

The Convener: Before she does so, I think it important to say that although Ross McGuffie gave us some encouraging numbers, the year-on-year figures show that the number of delayed discharges in Lanarkshire in January this year was higher than it was in January last year. The numbers that I have in front of me are 3,488 bed days in January 2018 and 4,211 in January 2019. Can we get some understanding of the context of those numbers and the contrast with the numbers that Ross McGuffie mentioned?

Ross McGuffie: The figures that I gave were for March to January and were the most recent ones that were reported by Information Services Division. It was the cumulative in-year total compared with the same period in the previous year.

The Convener: I was simply comparing the same points from this year and last year, and that shows an increase.

Ross McGuffie: I was taking the cumulative March-to-January position instead of just looking at the January figures.

The Convener: Okay.

Alex Cole-Hamilton: I think that the answer that Ross McGuffie just gave was probably one of the most comprehensive that I have ever had to that question, so well done. However, I share the convener's concern about this year's numbers.

Obviously the other side of that story is the social care environment in your health board area. Can you tell the committee a bit about capacity in that respect and whether, as we have experienced in other parts of the health service, part of the problem is that we cannot get people out of hospital because there is just no local authority or privately commissioned provision to cater for the package of care that they need?

Ross McGuffie: Recruitment is certainly a challenge across both partnerships. As far as home support is concerned, the workforce issue can be quite challenging. However, although there is an impact, the changes to the models that we have put forward have actually been quite positive, and our direction of travel in shifting the balance away from direct service provision to much more of a focus on earlier intervention and reablement will have the desired impact.

We have done quite a lot of research on discharge-to-assess models, and we have visited various partnership areas in England to review

their models and the impact that they have had. We have seen in other areas that a significant impact can be made through much earlier intervention, so that is the direction of travel for both partnerships.

For example, in the discharge-to-assess model, we were looking at equipment. The learning that we have gained from other areas is that, when there is a much earlier intervention that gets the individual home earlier, although the equipment needs to go in on the day, which is a pressure on the system, the number of pieces of equipment falls quite significantly. There is a significant challenge in the transition to that model, but we know that its longer-term impact will reduce demand. That is the direction of travel that we are pursuing.

The Convener: You have said that the number of early discharges is up, but emergency department admissions are up, too. Is there a danger that people will go out one door and in the next?

Ross McGuffie: One element is to build up the rapid response capabilities in primary care. Our initial focus in both partnerships has been on developing those capabilities for use at the back door. In reality, we need those rapid response teams in the community to pick up the front-door element, too. That rapid unscheduled care approach needs to be available in communities to reduce the numbers of patients going in the front door.

Neena Mahal: Mrs Knox can expand on what we are doing at the front door to support that.

Heather Knox: I will pick up the point about how we use hospital at home, which Calum Campbell mentioned earlier. Our main focus is on patient safety and doing the right thing for that patient at that time. We try to stick to that. Sometimes, that means that we have older patients who have dementia, or who have come in with an infection and have delirium, in our emergency department for a bit longer; we do not want to move them around the hospital to other wards, because that is very disorientating for them.

We have a service in Lanarkshire called hospital at home, which has grown like Topsy over the past three years. We have a team that can take many patients home using that support. It is a virtual ward environment; patients can have drips, infusions and much of the care that they would receive on the ward, and they are under a consultant, but they are cared for in their own home. On any given day, we can now support about 90 patients in that environment across Lanarkshire. That is one of the reasons why we sometimes have a person waiting a bit longer in the emergency department, but that is the right thing for that patient.

Lanarkshire is unique in that it has an emergency referral centre. The GPs phone a single access point when they want to admit a patient, which is unique in Scotland. I was involved in setting that up when I was a regional planning director many years ago—it is nice to come back to it. When the GP phones in, they are given the option of hospital at home at that point. The GP can refer the patient straight to hospital at home and our team will come out to the patient, rather than the patient coming into the emergency department. It is not just about the numbers and the four-hour waits or the eight-hour waits—it is about the patients and what is the right thing for them.

Brian Whittle: I have a simple question on the GP contract. How supportive are the GPs in Lanarkshire of the new GP contract and all that it entails?

Neena Mahal: I will ask Dr Findlay to respond to that—if she can.

Dr Findlay: How much time do we have left?

The Convener: Time is running out.

Dr Findlay: As the committee will know, only 30 per cent of GPs voted on the new contract and only 70 per cent of that 30 per cent voted in favour of the contract. Across Scotland, we are dealing with very small numbers. We can think about the reasons for that.

In Lanarkshire, we have developed some very good relationships with our GP sub-committee and it is very supportive of and has signed off our primary care improvement plan. We also need to get around the GPs themselves. We have cluster quality leads, who are GPs who lead on quality for several practices in their area. We have very strong links with and are very supportive of those leads.

At the moment, for GPs there is a tension between sustainability and the move away from the old model of general practice. That move towards being much more involved in the managed service in their localities could be seen as the biggest change in general practice since 1948. We are working through some of those challenges at the moment. However, GPs have mostly embraced the new contract positively. Trust among GPs has grown, and where there are sustainability issues, people come forward much earlier to allow the board to help them.

Brian Whittle: How does the board monitor the performance of GPs and GP practices? Will the new contract change the way in which that is done?

11:45

Dr Findlay: Yes, that is a big change for everyone. The quality and outcomes framework, which we used to use to monitor practices, went in 2016 and was replaced by the transitional quality arrangements and primary care indicators. Board officers cannot view the primary care indicators for their own board on the Scottish primary care information resource—SPIRE—which stops us using them to monitor quality. That was partly about getting the trust of GPs and quality leads, so that their data could be extracted and used centrally to help them to improve quality.

With the QOF gone, we realised that we had nothing else in place to monitor quality. We decided to look at prescribing, which Dr Burns talked about. We can look at that by locality, practice and individual, which can be helpful.

We also look at complaints, which we do not like getting. We ask our independent contractors—not only GPs but others—to report quarterly on their complaints. The board now sometimes mediates in complaints about practices, rather than the complaints going straight to the Scottish Public Services Ombudsman, although that often happens.

SPIRE, which I touched on, extracts data from GP practices. Our cluster GPs work with local intelligence support team—LIST—analysts to look at the data for their area and think about quality.

As a board, we can look at the discovery system, which is run by NHS National Services Scotland and lets us look at things such as referral rates, readmission rates and emergency department usage. We have set up a quality improvement programme on that in one locality and the GPs in that area have agreed to look at those indices and work with us to reassure us and help us to improve the quality there.

We have good relationships with our cluster quality leads and locality lead GPs, which helps, too. There are a number of enhanced services in GP practices that are monitored by the board.

Brian Whittle: I read that primary care in Lanarkshire receives the lowest payment per head of population of all the territorial boards. Will you expand on that?

Dr Findlay: Yes. If we can have more money, we would like that. [*Laughter*.]

Brian Whittle: I will sort that.

Dr Findlay: Perfect.

As Mr Campbell said, we use what we get wisely. Increasingly, GPs are integrated into the integrated community support teams in both IJB areas. In that way, we maximise use of GPs because some of the work is picked up by those teams to keep people at home. It is about a full-systems approach.

The Convener: It has been suggested in the past that one of the issues in Lanarkshire is that rather than going to their primary care provider—as people in other parts of the country might do—people go to emergency departments. Is that still an issue in Lanarkshire?

Calum Campbell: It is a reasonable observation for people to make. One of Lanarkshire's challenges is that there are three district general hospitals that are quite close to population centres, so access to secondary care is relatively easy. When we compare the population use of Aberdeen royal infirmary in the Aberdeen and Aberdeenshire local authorities with that of the hospitals in North and South Lanarkshire, we find that people are twice as likely to turn up at a hospital in Lanarkshire. I think that that is driven by the geography and close proximity of the hospitals to the population, as well as by population deprivation. I dare say that if we had more general practices, that would help the situation. It is a combination of issues.

Brian Whittle: I am also really interested in GP cluster working and the multidisciplinary teams that are developing. How do you prioritise locality planning and health inequalities in Lanarkshire?

Dr Findlay: Are you thinking about multidisciplinary teams and how we use them?

Brian Whittle: Yes.

Dr Findlay: When we roll out the resource that comes to the primary care improvement plan, it is allocated on a locality basis. We have taken the view that there will be a levelling up of services, to start tackling some of those health inequalities, so better-resourced areas get the additional resource later on.

Within each locality, the locality lead GP, the cluster quality lead GP and the locality general manager are all involved in discussions about how that resource is best used within their locality, so that if practices are struggling, or if there are pockets of deprivation, they will get the resource first. It will then level out over the three years.

Underpinning the whole primary care improvement plan will be an evaluation. As part of that, our GP colleagues have asked us to make sure that allocation is fair across the piece, as I am sure you can imagine. They are working with us to develop that as we speak. It is a very new way of delivering general medical services, so it is almost partnership working as we go along, but with a fundamental levelling up of services—certainly not a levelling down—so that we have a level playing field.

Brian Whittle: I have one more question, and I am not ashamed to put on my hat as convener of the musculoskeletal and arthritis cross-party group. Within a multidisciplinary team, we know that one in five people presenting at a GP practice will have some sort of MSK issue. We would also probably agree that, in most cases, a physiotherapist would be the best person to deliver treatment for that. There is a suggestion that there is a shortage of level 7 physiotherapy for GP practices, GP clusters and multidisciplinary teams, and that they are moving from the hospital environment into the GP environment. Is that the case?

Dr Findlay: They are robbing Peter to pay Paul. It is certainly a risk and, as we heard earlier, when we train people up to level 7, there is also a risk that they will move to other boards. Within Lanarkshire, we are looking at a "Grow your career in Lanarkshire" approach, such that, within the primary care improvement plan, a range of physios would be working within general practice and making sure that it is governanced and safe, so that we can attract people and they can grow their career with us—they can have a career ladder up to band 7.

We are also working closely with the enhanced service physios. We might even work a rotational model. That is being worked up as we speak, so I cannot give you much more information about it at the moment. It will mean that people retain their experience not only in primary care but in the acute care setting and back out. That will, we hope, improve job satisfaction among our physios and enable us to future proof the service. There is no doubt that people who have MSK problems want to see physiotherapists, and possibly an advanced physiotherapist, rather than going to their GP, where they will probably end up with a prescription and not much else.

Brian Whittle: Do you have enough physiotherapists in the system?

Calum Campbell: The short answer is no. It is one of our pressure areas. Yesterday we had a conversation with the University of the West of Scotland: we will do some work together to profile all the demands on physiotherapy to see whether there are other professionals whom we can use to offset some of the work. We are short of physiotherapists.

Emma Harper: Physiotherapists are needed for pulmonary rehab, and the fact that there is a high number of smokers in Lanarkshire will have a knock-on effect on pulmonary ill-health. I declare that I am the convener of the cross-party group on lung health, so I have an interest in smoking cessation, pulmonary rehab and social prescribing for prevention of type 2 diabetes. Tell me a wee bit about the success or benefits of social prescribing in NHS Lanarkshire. Do you have pulmonary rehab processes in place to deal with lung ill-health?

Ross McGuffie: We have a social prescribing programme called "Well Connected", which includes a range of elements from pulmonary rehab classes and wider fitness classes through to stress control, anxiety management, mindfulness and so on. A range of different programmes is available to GPs and through our own occupational health services for referral.

It is an area that we are keen to develop in partnerships plans and in the strategic commissioning plans. The tech agenda is critically important as well. There have been some great pilot projects in North Lanarkshire around home health monitoring. If we take respiratory health as an example, we have issued some simple technology to individual patients. They can take a reading using a pulse oximeter, text the reading to the service and get an automated response. If the reading is beyond a certain value, they get a text message back, which gives them advice and asks them to take another reading in 30 minutes then send it to the service. If required, a respiratory nurse will visit the patient at home that day. The tech agenda to enable that service is really important.

Another example is the development of the "Making Life Easier" website, which is a portal that is used in North Lanarkshire to provide self-management advice and supported self-assessment. It gives individuals a range of simple equipment options to order for their home, which allows people to take control of their condition and connects them to the service, where required. That connection is not done automatically, as the council is trying its best to support the individual to take control.

In the commissioning plans for North Lanarkshire and South Lanarkshire, we are trying to develop supporting people to take control of their conditions.

Sandra White: You will be pleased to know that I am not—as far as I know—the convener of any cross-party groups on health. I am really impressed with some of the figures that you have mentioned, particularly in relation to integrated teams and people being able to get out and get support. I hope that other health boards take that on board. If the convener will indulge me, could you perhaps send us the papers relating to delayed discharge and how people are supported when they leave hospital? It is really important, including for a personal matter—I am asking from a personal point of view, rather than as a committee member.

Neena Mahal: We would be happy to send the papers.

Sandra White: That would be wonderful, thank you.

We know about the pressures and that one of the pressures on the health board is the new Monklands hospital. It is a pressure not only on capital projects and in monetary terms but, I imagine, on staff morale and the board's ability to retain people. It is a sensitive subject that is out for public consultation, so I cannot dig too deeply on the issue. There are two possible new sites for the hospital—Gartcosh and Glenmavis—and a report was meant to be published in February this year. Could you enlighten the committee on where you are at the moment, or whether anything is moving?

Neena Mahal: Maybe I could respond to the question initially, and then Mr Campbell can come in. The first thing to say is that you will be aware that an independent review has been commissioned by the cabinet secretary to look into the consultation process that we carried out in relation to refurbishment or replacement of Monklands. The independent review group was due to report at the end of February, but it has recently indicated that it will now not report until the end of May. Therefore, the committee will appreciate that I am able to share only limited information and that it would be inappropriate to say too much about that.

I will say that the Monklands site is a key plank of our clinical strategy—having a replacement or refurbished hospital is part of it. The hospital is now more than 40 years old. If we are to be able to deliver our clinical strategy and achieve excellence—notwithstanding the discussion that we had earlier about attracting and retaining staff and enabling them to work in an environment that provides them with state-of-the-art facilities—that new hospital will be absolutely crucial.

We have challenges—Sandra White mentioned staff morale. I will ask Mr Campbell to talk about some of them. One of the key challenges is the physical environment of the building and the amount of backlog maintenance. More important, that environment means that we cannot always deliver services in the way that we wish to deliver them. That is key. It is not just about the physical environment; it is also about delivering the services how we want to deliver them.

12:00

Calum Campbell: Let me set the context. Between 2015-16 and 2017-18, NHS Lanarkshire took its backlog maintenance requirement from about £53 million down to about £42 million. Broadly, that drop was because we had the three new health centres. Of the £42 million that remains, more than £31 million relates to Monklands hospital. There is a physical-fabric problem at Monklands. I think that we are the only board that is moving revenue to capital for maintenance. We welcome the commitment to replace or refurbish Monklands, but it is imperative that we make rapid progress on that.

Sandra White rightly made the point about recruitment of staff, which is an issue for us. Our nursing vacancies are greater on the Monklands site than they are on the other sites. It is not attractive to people, and the uncertainties make it more difficult to recruit staff. Dr Burns might speak briefly about the functional suitability of the site.

Dr Burns: What Calum Campbell said is right. The site is a contributory factor in issues to do with recruitment and retention of the medical workforce at Monklands hospital.

The functional suitability becomes challenged because of the old infrastructure of the building. I am not an expert, but I understand that the drainage system is not conducive to allowing the appropriate level of run-off, which results in back-flow of human effluent—sewage. That happens about once a year and interrupts delivery of safe patient care, which is extremely demoralising for staff.

Throughout the year, there are challenges to do with the fabric of the building and maintaining the required Healthcare Environment Inspectorate hygiene levels. The Staphylococcus aureus bacteremia rate in Monklands is marginally higher than it is in our other two hospital sites. That could be to do with the patient-case mix and the renal unit at the hospital, which contributes to the higher rate. Nevertheless the higher rate is a consistent feature.

All those things make it extremely challenging to maintain staff morale and deliver a high-quality service.

Neena Mahal: I assure members that we have put in place mitigating actions to deal with backlog maintenance, and that we are working closely with staff. However, certainty about the future would be helpful.

Sandra White: I hope that there is a conclusion sooner rather than later, to serve the people of the area, who have a great affinity with Monklands hospital.

There was some controversy about how the board went about public involvement, which was covered in the press. That was unfortunate. In that light, if you had to do it again, would you approach it differently?

Neena Mahal: The first thing to say is that we will, of course, learn any lessons that come out of

the review; we welcome the review. It is important that we consult and engage with the communities that we want the hospital to serve. I think that we always reflect on such matters and ask ourselves whether we could have done things differently and better. Hindsight is always a good thing. However, I await the outcome of the review and look forward to implementing the recommendations.

David Torrance (Kirkcaldy) (SNP): I have questions about maintenance and infection control. Can you provide information on the routine monitoring that is undertaken to test for contamination, including of the water supply and ventilation system, before patients become infected?

Dr Burns: Committee members might have seen our response to the recommendations that came out of the inspection of the Queen Elizabeth university hospital.

The long-standing Lanarkshire infection control committee has a number of sub-committees that report to it; that is the governance structure for our healthcare environment. Standard procedures have been put in place, through those sub-committees, to give assurance to the Lanarkshire-wide committee on how, for example, the process for in-line flushing in high acuity areas is managed, and how the integrity of the environment is maintained on a regular basis. Quite stringent assurance is provided to the committee.

David Torrance: Is the health board directly responsible for employing all the cleaning and facilities staff at all its sites?

Neena Mahal: We have three sites: two are PFI and the third—Monklands—is not.

Dr Burns: There is therefore a difference: the staff at Monklands are our staff. They are responsible for cleaning the hospital environment. As we said, that is challenging, given the fabric of the Monklands hospital building. There are challenges with recruitment of domestic staff.

The other two hospitals are PFI hospitals, so there is an output specification, which is monitored through our internal governance processes, to make sure that that output is achieved.

David Torrance: How much involvement do your infection control staff have in monitoring maintenance and the different cleaning systems across all your sites?

Calum Campbell: They are essential to that.

David Torrance: Last but not least, how much input will infection control staff and specialist engineers have into the design of future maintenance contracts for the new Monklands hospital?

Calum Campbell: They were going to have an important role—as a result of the issues at Queen Elizabeth university hospital, they will have a central role. The point is similar to the one that the chair made about the consultation on Monklands hospital: whatever comes out of the review process, we need to ensure that lessons are learned and that we get the benefit. We want to ensure that we end up with a state-of-the-art hospital when Monklands is replaced or refurbished. Whatever the design issues are, we will need to ensure that they are picked up by the engineers and so on.

David Torrance: Thank you.

The Convener: The witnesses will know that the committee took evidence on healthcare environment hazards. One of the things that we heard from witnesses was that infection control doctors are not always involved in the design of new buildings, so it is reassuring that you are planning to take that issue on board.

I thank you all for your evidence, which has been informative and helpful. There were a number of issues on which you undertook to send us further information, so we look forward to receiving that. If, in our discussions after this part of the meeting, we identify other areas on which we would like supplementary information, we will be in touch with you to that end.

12:08

Meeting continued in private until 12:16.

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

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

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

The Scottish Parliament
Pàrlamaid na h-Alba