PUBLIC AUDIT AND POST-LEGISLATIVE SCRUTINY COMMITTEE

AGENDA

30th Meeting, 2018 (Session 5)

Thursday 20 December 2018

The Committee will meet at 9.00 am in the Adam Smith Room (CR5).

1. Decision on taking business in private: The Committee will decide whether to take items 4, 5 and 6 in private.


   John Burns, Chief Executive, NHS Ayrshire and Arran;

   Professor Elaine Mead, Chief Executive, NHS Highland.


   Paul Gray, Director-General Health & Social Care, Scottish Government and Chief Executive, NHS Scotland;

   Christine McLaughlin, Director of Health Finance, Corporate Governance and Value, Shirley Rogers, Director of Health Workforce and Strategic Change, and Dr Catherine Calderwood, Chief Medical Officer, Scottish Government.

4. Section 22 reports - The 2017/18 audits of NHS Highland: Financial sustainability and NHS Ayrshire and Arran: Financial sustainability: The Committee will consider the evidence heard at agenda item 2 and take further evidence from—

   Caroline Gardner, Auditor General for Scotland;
Claire Sweeney, Audit Director, Performance and Best Value, and Leigh Johnston, Senior Manager, Performance and Best Value, Audit Scotland.

5. **Section 23 report - NHS in Scotland 2018**: The Committee will consider the evidence heard at agenda item 3 and take further evidence from—

   Caroline Gardner, Auditor General for Scotland;

   Claire Sweeney, Audit Director, Performance and Best Value, and Leigh Johnston, Senior Manager, Performance and Best Value, Audit Scotland.

6. **Work programme**: The Committee will consider its approach to its future scrutiny of the Auditor General for Scotland's report on the 2017/18 audit of the Scottish Police Authority.

   Lucy Scharbert
   Clerk to the Public Audit and Post-legislative Scrutiny Committee
   Room T3.60
   The Scottish Parliament
   Edinburgh
   Tel: 0131 348 5390
   Email: papls.committee@parliament.scot
The papers for this meeting are as follows—

**Agenda Item 2**

Note by the Clerk  
PAPLS/S5/18/30/1

PRIVATE PAPER  
PAPLS/S5/18/30/2  
(P)

**Agenda Item 3**

Note by the Clerk  
PAPLS/S5/18/30/3

PRIVATE PAPER  
PAPLS/S5/18/30/4  
(P)

**Agenda Item 6**

PRIVATE PAPER  
PAPLS/S5/18/30/5  
(P)
Public Audit and Post-legislative Scrutiny Committee

30th Meeting, 2018 (Session 5), Thursday 20 December 2018

Section 22 report – The 2017/18 audit of NHS Highland and the 2017/18 audit of NHS Ayrshire and Arran

Introduction

1. At its meeting today, the Public Audit and Post-legislative Scrutiny Committee will take evidence on the section 22 reports on the 2017/18 audit of NHS Ayrshire and Arran and the 2017/18 audit of NHS Highland from—

   • John Burns, Chief Executive, NHS Ayrshire and Arran; and
   • Professor Elaine Mead, Chief Executive, NHS Highland.

2. The Committee took evidence from the Auditor General for Scotland at its meeting on 1 November.

3. The Committee has received written submissions from both boards and these are attached in Annexe A. The Committee also received information from NHS Highland and from Audit Scotland on the costs of agency locum staff. That information is attached in Annexe B.

Clerks to the Committee
17 December 2018
Annexe A

Submission from NHS Ayrshire and Arran

NHS Ayrshire & Arran is committed to the principles of the triple aim as it seeks to reform and create a sustainable health and care system; improving the patient experience of care (including quality and satisfaction); improving the health of our population; and reducing the per capita cost of health care. Our programme of reform is in the context of the national policy and strategy framework. NHS Ayrshire & Arran has acknowledged this framework in a series of papers developed over this period, from “Our Health 2020” presented to the NHS Board in 2014 and most recently in 2016 in the “Delivering a Balanced Health and Care System”.

In September 2016, NHS Ayrshire & Arran set out its intention in its Transformation Change Improvement Plan. The plan described the ten year ambition to make transformative change and defined the ‘Integrated Health and Care System’ designed in collaboration with our Health and Social Care Partnership (HSCP) colleagues to place the individual at the centre of the continuum of health and care services that are offered. Under the banner of #CaringforAyrshire, the portfolio of whole system transformation has progressed to deliver this ambition.

NHS Ayrshire & Arran and our three Integrated Joint Boards (IJBs) are well recognised for our approach to integration, with strong collaborative working across the spectrum of health and care services. Robust links with our Community Planning Partners acknowledges the impact of wider determinants such as housing, employment, low income and educational attainment on individual and population health and conversely, of healthy and economically productive citizens on developing vibrant, attractive communities. Within this framework, we have embarked on a significant programme of transformation and reform of our health and care services. Our focus on redesigning these services was to better support the needs of our citizens now and in the years to come.

To support the scope of the Portfolio of change we established a Programme Management Office (PMO) in 2017 to assist in the identification and development of programmes of change, monitor and challenge delivery against plan and ensure appropriate reporting in line with governance arrangements to scrutiny groups, Corporate Management Team, Board Governance Committees, the NHS Board and IJBs. These arrangements guarantee that there is clarity and common understanding around delivery of outcomes, position against trajectories/targets and outcomes and knowledge of necessary mitigation when required.

Our portfolio of transformation seeks to redesign and optimise service delivery across all areas of health and care and includes programmes in Unscheduled Care, Primary Care, Planned Care, Mental Health with key enablers in developing our Estate to support future service models and making best use of Digital services to modernise
and digitally enable service delivery. Recognising that transformation and reform on this scale must be sequenced and co-ordinated to deliver desirable outcomes, a number of priority areas were identified for 2018/19.

**Primary Care – Ambitious for Ayrshire**

The Ambitious for Ayrshire Programme was established in 2016 by the East Ayrshire HSCP, as lead partner for Primary Care services, to provide strategic oversight for the range of workstreams and projects across Primary Care services. Following the success of these projects in 2017/18, and with the introduction of the new GMS contract framework, the full spread and roll out of these services were included within the pan Ayrshire Primary Care Improvement Plan (PCIP). The PCIP was signed off on 28 June 2018 by the three IJBs, GP Sub Committee, and NHS Board in Ayrshire. This approach to working in partnership to produce one plan for Ayrshire is typical of our approach towards integrated and partnership working in Ayrshire.

The PCIP sets out a number of priorities to be delivered in year one (2018/19). The two main areas are the roll out of the Pharmacotherapy Service and enhancing the MSK Physiotherapist Service, with these professionals being based in GP Practices where possible. A successful recruitment process throughout July has ensured that we have been able to appoint and implement these priority areas.

**Redesigned Bed Model**

In both University Hospital Ayr (UHA) and University Hospital Crosshouse (UHC) there has been a programme of clinically led specialty redesign over the last 18 months that has shaped the bed model and how our ward spaces are best utilised in line with provision of that specialty care. These service reconfigurations alongside the development of our wider transformation programme, examples of which are listed above and below, have enabled the closure of beds as we look to provide more care through community teams and services in line with the Health and Social Care Delivery Plan. To date this programme has facilitated the closure 42 beds at UHA and 54 beds at UHC.

**Realistic Medicine – Effective Prescribing**

Effective Prescribing is in line with the triple aim principles and is focused on improving the quality of prescribing, improving patient outcomes, reducing harm from over prescribing (polypharmacy), reducing unwarranted variation and achieving best value from medicines. The approach to achieving efficiency savings in prescribing across both Primary and Secondary Care is aligned with the principles of realistic medicines use and follows the five key national strategy areas of polypharmacy, respiratory, diabetes, chronic pain and antimicrobial prescribing.

An example of one of the projects within this programme would be the approach to identified variation in prescribing practice visible in national benchmark data which has led to a targeted approach to improvement being developed. Where variation in
prescribing practice is visible in this data, scrutiny highlights areas of improvement from both a patient safety and improved patient outcome perspective alongside potential financial efficiencies.

Respiratory was identified as the prescribing costs were very high and the outcomes such as COPD mortality and patient admissions to hospital were poor. Working with the Respiratory Managed Clinical Network a whole system package of prescribing measures were introduced to improve the quality of prescribing and reduce costs (reduction in use of high dose inhaled steroid inhalers). It was agreed that a proportion of the savings would be invested in more cost effective interventions as part of a respiratory care pathway e.g. respiratory specialist nurses and pulmonary rehabilitation.

The respiratory prescribing-to-care work has improved the quality of prescribing, reduced costs and allowed investment in additional respiratory nurses and pulmonary rehabilitation services to support overall improvements in patient outcomes. The results from work in this area to date show a decrease in prescribing of these high dose inhaled steroid inhalers relative to the previous quarter of 0.48% compared to 0.01% nationally for the same quarter.

**Workforce**

Recognising that the biggest resource we have in the NHS is our staff and that there are known challenges in recruiting, retaining and utilising this precious resource effectively, NHS Ayrshire & Arran have a Workforce Programme which endeavours to ensure that these challenges are managed effectively. The programme covers areas such as absence management where we have a successful programme looking to support staff who have long term sick absence; utilisation of medical and nursing agency where we have trajectories to minimise their use; analysis of use of overtime, excess part time hours and bank usage by operational area; and scrutiny of vacancies and their fulfilment. This programme seeks, through tight operational grip, to optimise the use of our workforce resource.

**Intermediate Care and Rehabilitation**

A pan Ayrshire model for Enhanced Intermediate Care and Rehabilitation was developed throughout 2017 as part of the programme of work looking at services for Older People and People with Complex Needs. This model focuses on providing high quality care and support through pro-active early intervention and preventative action to stop older people and people with complex needs becoming unwell in the first place or supporting them to manage their conditions more effectively. When deterioration is unavoidable, the model aims to create integrated, multi-disciplinary services delivered in the home and in the community through health, social services, third and independent sectors to prevent unnecessary hospital admissions and get people home from hospital quickly.
This business case for the Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation was approved in February 2018. An investment of £2.5m over two years is required to enhance existing Intermediate Care services to offer seven day working. This transition funding will reshape existing service provision in order to realise efficiencies through Partnership based Intermediate Care and Rehabilitation Hubs whilst working with Acute Care of Elderly (ACE) Practitioners and specialists based in the Acute Hospitals in order to get people home as soon as appropriate. These changes will improve care quality and people’s experience of care; it will reduce attendances and admissions to hospital and support smoother transfer of care from hospital services to community health and care services. This model went ‘live’ on the 19th November and it is anticipated will support, in the first instance, seasonal demands of the winter period.

**Mental Health Services**

The National Mental Health Strategy 2017 - 2027 recognises that in the last decade mental health services have changed dramatically. There has been a transformation in mental health with advances in care, the development of community based mental health services and a greater emphasis on human rights. Similar to the process described earlier for Primary Care Improvement Plans, North Ayrshire HSCP, as lead partner for Mental Health Services, co-ordinated the production of a single plan for Ayrshire for the Action 15 monies detailing clear proposals to enhance and build workforce capacity in key service areas in Crisis services, Police triage, A&E, GP practices, justice services and Prison services.

The Mental Health Services programme of transformation has also focussed on the following key areas in year.

Following the opening of the Woodland View site in May 2016 and the transfer of services, there has been a planned reduction in the use of the Ailsa site for inpatient services. A small number of services remain including; long stay adult mental health services and services for older adults with cognitive impairment with complex and challenging care needs. A programme of work is underway to provide alternative care for these service users in the most homely and least restrictive environment that meets their needs.

The Trindlemoss Court Project will provide a pan Ayrshire community mental health rehabilitation facility. Housing tenancies with care and support for complex learning disabled individuals and/or individuals with autistic spectrum conditions will be co-located on the site along with a residential community resettlement from hospital facility for people with learning disabilities and a North Ayrshire Learning Disability Day Service. This facility will be fully operational by June 2019.

**Planned Care**
NHS Ayrshire & Arran have worked with support from Scottish Government to improve the position with access to planned care services. Our performance in this area, whilst not on target, has improved considerably over recent years. In October 2018, Scottish Government introduced the Waiting Time Improvement Plan (WTIP).

Funding is being made available to support this and NHS Ayrshire & Arran have submitted their improvement plans, including trajectories, to the Scheduled Care Performance and Delivery Directorate. Given our successful approach in recent years, we anticipate that this ongoing support will enable us to continue to improve in this area and meet the requirement of the Waiting Times Improvement Plan.

**In Year Outcomes**

Our programme of transformational change is successfully delivering outcomes in quality improvements, service performance and is on track to deliver £27m of financial efficiencies in 2018/19. Some examples of in year outcomes are described below.

Service redesigns such as the opening of Combined Assessment Units (CAUs) at both University Hospital Ayr (UHA) and University Hospital Crosshouse (UHC) have visible impacts in attendance and admission data. Data shows that presentations at our Emergency Departments (ED) and CAUs are increasing however the numbers converting to a true inpatient admission (i.e. removing any paediatric assessment patients and CAU assessment patients that are currently coded as admissions from the admission data) is declining. This demonstrates that our model of ‘assess to admit’ is working and that only those that require an inpatient stay are being admitted to the hospital.

A trajectory to reduce spend on nursing agency has been successful, bringing both quality improvements to service delivery through continuity in staff care and in financial efficiencies. The spend on nursing agency was successfully reduced from £3.1 million in 2016/2017 to £1.9 million in 2017/2018. In 2018/19, an improvement trajectory to deliver a further £1m reduction in spend on nursing agency staff is on target to be achieved. In the first seven months of 2018/2019, agency nursing spend in acute services was £0.3 million. Medical Agency expenditure has been a major focus of attention for a number years and a £1.0 million reduction target was included in the 2018/2019 plan. Medical Agency spend is at its lowest level since 2015/2016.

Our work in 2018/19 to redesign the bed complement has seen 42 beds close at UHA and 54 Beds at UHC. Staff aligned to these beds have redeployed to vacant posts as part of agreed process throughout this period of redesign. It is anticipated that this programme will deliver £2.8 million of savings by the year end.

The Realistic Medicine Effective Prescribing programme is split across Acute and Primary Care projects. The Acute Prescribing Plan has a target saving of £1.65 million, our forecast shows we are already ahead of trajectory at £1.82 million due to significant savings from National Procurement which were not anticipated. The Primary Care
prescribing target for 2018/19 was £2.744 million. Currently, we are reporting an aggregate of £1.8 million which is better than the projected position. The focus will be to continue to drive prescribing quality strategies to improve patient outcomes and reduce harm from over prescribing and to deliver associated savings.

3 Year Plan

Following the publication of the, “Health and Social Care: Medium Term Financial Framework” on 4th October and subsequent direction from the Director of Health Finance, Corporate Governance and Value, NHS Ayrshire & Arran is developing a three year plan, beginning financial year 2019/20. The diagram at Appendix 1 shows how our Strategy #Caring for Ayrshire is delivered through our transformation programme which in turn informs our service plan that will describe the elements of service redesign and transformation across health and care services over this period. The requirements of the service plan will influence the development of the other component plans namely, the Workforce plan, Quality and Safety Plan, Infrastructure plan and Revenue Plan.
Whole System Transformation

Our Health 2020
- Model of Care
  - NHS A&A
  - WoS

Mental Health
- Mental Health Strategy

Children
- Best Start
  - GIRFEC

Primary & Community Care
- New GMS Contract

Infrastructure
- Digital Strategy
- Estate Strategy

Transformational
- ‘Right Care, Right Place’
- End of Life Care
- Older Adults
- Unscheduled Care

Service
- Performance Improvement
- Quarterly Performance Meeting

People
- People Plan
- Review of Partnership Arrangements

Quality
- Quality Improvement
- Safety Programmes
- Excellence in Care

Finance
- Best Value
- Quarterly Performance Reviews
- Scrutiny Groups

Operational

0-3 yrs
- Service Plan
- Workforce Plan
- Quality & Safety Plan
- Infrastructure Plan
- Revenue Plan
Submission from NHS Highland  
The 2017/18 audit of NHS Highland | Financial Sustainability

Introduction

The Auditor General’s Report provides an overview and high-level analysis of NHS Highland current and predicted future financial challenges. She points to some of the key cost pressures for the board in 2017/18 including prescribing; adult social care; and a failure to achieve a more sustainable workforce model. Despite unprecedented levels of £30m savings achieved in 2017/18 brokerage of a further £15m was required.

Further in her evidence to the Committee on 1st November 2018 she also made a number of points about the NHS in Scotland in general including that:

- All boards are struggling with balancing the three sides of the triangle:
  - finances,
  - waiting time and
  - quality of care,
- At a national level the workforce is under pressure through:
  - Rising turnover and sickness absence
  - Increasing difficulties in recruiting
  - Issues relating to locum and agency staff is a ‘significant problem’ with no ‘quick fix’

And she highlighted that: “From our work across the National Health Service in Scotland, I would say that all boards are facing significant financial pressures for very understandable reasons to do with demographic challenges, which brings with it increasing demands. However, each board tends to have a different combination of factors that cause it specific local challenges.”

Notably, The Auditor General’s comments very much resonate with the analysis undertaken by NHS Highland of the challenges faced which we set out in our Quality and Sustainability Strategy and Plan, published in May 2017. It is within this context that NHS Highland would like to submit some brief supporting narrative for committee members highlighting local factors.

NHS Highland Quality and Sustainability Plan

Our Quality and Sustainability Plan, published in May 2017 stated that:

“Across the country - and beyond - the challenges to bring in better ways of working and different models of care that are sustainable from both a staffing and a financial viewpoint are significant. Here in Highland we also face some additional pressures due to the remoteness and rurality of some of our communities, plus we have a higher proportion of older people than most parts of Scotland.

The biggest challenge is how to speed up the pace of change whilst coping with the inevitable impact of meeting current needs and targets within resources.

Financial sustainability | costs and cost pressures
The Auditor General highlighted that the main cost pressure across all boards in 2017/18 were linked to including achieving a more sustainable workforce model and rising costs of adult social care. Across the board area there are a number of challenges causing pressure on our workforce:

- Increasing specialisation in medicine mean that consultants are no longer trained in a way that allow them to work in generalists settings, such as Rural General Hospitals
- Significant challenges with recruitment in general especially in remote and rural areas
- Over half of the staff are aged 50 years of age or over

**Costs of medical locums and supplementary staffing**

One of our key pressures is the expenditure on medical locums, where we have spent in the region of £15m in each of the last three years. Currently we have 36 consultant vacancies out of an establishment of 275 (13.1%) almost double the consultant vacancy rate for Scotland (7.5%).

GP vacancies are harder to assess but NHS Highland now manages 12 salaried practices. The national shortage of GPs hit Highland first, and harder, a barometer for what was to follow across Scotland than anywhere else in the country. However, this does mean that we have greater experience in delivering new approaches. We estimate that currently 12% of practices in Highland have a vacancy half that being reported for Scotland as a whole (24%). We have developed a number of initiatives and multi-disciplinary approaches to address the challenges. However, the next tranche of GP retirements poses a further risk to sustainability.

**Wider cost implications**

Another challenge is how we maintain equity of service across the board area balanced with the wider sustainability challenges. For instance the cost per case varies enormously across our health and social care systems. As an example out of hours, cost per contact, varies from less than £70 (Inverness) to greater than £1,400 (Wester Ross).

**Major redesign to transform models of care**

At the publication of Auditor General’s annual review of the NHS in Scotland in 2018 she commented: “The solutions lie in changing how healthcare is accessed and delivered, but progress is too slow.”

In her report she also says “Changing how healthcare services are accessed and delivered is a long-term, complex undertaking.”

In many ways these two statements sum up the challenge of transforming services and certainly resonate with our own experience.
The board has an ongoing programme of service redesigns across districts (Caithness, Sutherland, Lochaber, Badenoch and Strathspey, Skye, Lochalsh and South West Ross). These are all predicated on trying to deliver the Scottish Government’s 2020 vision and provide more community based services with less reliance on hospital and institutional care. These new models will be more sustainable but they have proven to very difficult to consult and agree. Even where there has been a consensus, through public consultation, decisions have come under constant public and political challenge. Not surprisingly the pace of change has been very slow.

Such challenges were highlighted in the Auditor General’s report, NHS in Scotland 2017 where it was stated:

“People are closely invested in their local health services, and there continue to be many examples by public and political opposition to attempts by NHS board to change how services are delivered.”

Even though we have continually put NHS staff, local communities and the public at the heart of change, and involve them in planning how future services will be delivered, we have not found a quicker way to do this. Every community is unique and their historical range and location of services is critical context when looking to redesign service.

Rural General Hospitals

The committee discussed the significant cost of two locums at the meeting on 1st November. This was followed up with a request by the chair for a response which was provided on 20th November 2018.

To summarise, there are six Rural General Hospitals (RGHs) in Scotland with NHS Highland managing three of these: Caithness General Hospital in Wick, Belford Hospital in Fort William and Lorn and Islands Hospital in Oban. The three other RGHs are based within the Island Board areas. These hospitals are our most expensive assets. Services consultant-led and provide general surgical and medical response and include 24/7 A&E.

Their strategic importance is because they are significantly distant from direct support of District General Hospitals, for example Raigmore Hospital. For this reasons RGHs are equipped and staffed to be able to resuscitate, stabilise, assess and prepare patients for treatment, discharge or transfer, and are key locations for the Scottish Ambulance Service for the receipt and stabilisation of acutely unwell patients.

These consultant posts have been increasingly hard to fill. In one of the hospitals, there is an establishment of 10 consultant posts currently with four vacancies (40% cf 7.5% vacancy in Scotland). In order to keep the service running our medical locum and agency spend has increased from £425K in 2012/13 to £1.7m in 2017/18.

The consultants are required to deliver a challenging 24/7 rota. One of the clinicians highlighted by the Auditor General undertook approximately half of all the on call for surgery in the hospital as well as normal weekday hours. Agency locums are paid by
the hour, including hours on call. The rate was £98.17 per hour and plus there was a commission fee to the agency which totalled £46k.

It is important to stress that the cost to NHS Highland would be the same if a number of different locum consultants has been used to cover the vacancy over the same period, which is often the case. Therefore whilst we fully accept and indeed welcome questions arising from high cost locums, it is important for the cost to be understood as part of the wider problem facing NHS Highland in recruitment of hard to fill vacancies.

**Adult social care**

NHS Highland is unique in that we were the first board to fully integrate health and social care services in 2012 through the lead agency model with the Highland Council. And, in 2016, as part of wider agenda, through the Integrated Joint Board arrangements in partnership with Argyll and Bute Council. Therefore we have experience of both models.

Under the lead agency spend on Adult Social Care has increased from £92m in 2012-13 to £125m in 2017-18. In 201718 the board overspent attributable to adult social care was £6m. Investment by NHS Highland into adult social care has been significantly greater than the quantum allocated by the Highland Council. This additional spend reflects both the increasing and changing demands of an aging population and the move to deliver more care at home. For instance young people are now living longer with complex care needs (n=131) and in 2017/18 cost £29m. Whilst this remains a good news story for these young adults and their families, there are undoubted challenges around affordability.

As the Auditor General summarises in her report “Health and Social Care integration: Update on progress”, November 2018

“Due to the way the Lead Agency was established and the underlying agency agreement, the risks all rest with NHS Highland. Any increase in costs must be met by the NHS board.”

The strategic thinking behind integration was to develop a model that would better meet the needs of an aging population and we believe that rationale still holds true. The board can demonstrate good outcomes, and in terms of redesign offers significant advantages. However we need to negotiate a fairer agreement with the Council that will share risks and ensure that as a Partnership we deliver sustainable services.

**Conclusions**

**ON PEOPLE** – There are rising public and political expectations yet in the face of these pressures our staff have always strived to deliver the best care possible that is safe.

**ON COMMUNITIES** - Local communities cherish their NHS and want local services maintained or strengthened. They do accept change but it is time consuming and
resource intensive process, as evidenced most recently in our wide-ranging public consultation in Caithness.

**ON MEDICAL WORKFORCE** – The solution cannot simply be about training more doctors in the traditional way or revising a recruitment strategy to attract more doctors. Rather it reflects the specialisation in medicine. The type of specialist generalist doctors we need for Rural General Hospitals are no longer trained. We have been creating new roles (Rural Practitioners) but it takes time.

**ON WORKFORCE IN GENERAL** – Half the workforce is over 50 years of age and it is more extreme in remote and rural areas.

**ON MODELS OF CARE** - Our models of care need to be designed where we can look after more people with fewer staff. While technology is playing a part wide-spread adoption has been too slow. The reasons for this are many, varied and complex

**ON PLANNING** – Tension between short-term delivery and longer term planning is also highlighted by the Auditor General, and the board would agree this needs attention. However, longer term planning in itself will not deliver the changes on the ground.

**ON GOVERNANCE** - Governance, management and leadership should rightly be scrutinised, at all levels. Any strengthening can only be helpful. Our local governance review has been published and we are working on implementing the recommendations.

**ON LOCAL CONTEXT** - From a NHS Highland perspective, however, there remain fundamental challenges posed by our demography, our geography, serving our remote and rural communities and our history (all critical re context for change and pace of change)

**ON SUSTAINABILITY** - The board has an in depth knowledge of our sustainability challenges. We agree with the Auditor Generals assessment across the NHS is that more money in itself will not solve the problem. Implementation at scale has been slow. This is due to the complex nature of making changes in NHS balanced with many competing demands. We face unique challenges with generally poor understanding of the challenges we face around the delivery of remote and rural health care. We would also welcome support to negotiate a fairer agreement with the Council as part of our Lead Agency model to deliver integrated services.
Annexe B

2017/18 audit of NHS Highland – locum costs

The Committee received information from both NHS Highland and from Audit Scotland about the two agency locum staff that were earning a salary in excess of £400,000. The salary costs for the two employees reflected in the remuneration report within NHS Highland's annual report and accounts is only the salary costs of the two individuals and excludes the additional agency costs paid. NHS Highland have provided a breakdown of the costs associated with the two members of staff in question.

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Introduction

1. At its meeting on 15 November, the Committee took evidence from the Auditor General for Scotland on her section 23 report the NHS in Scotland 2018. Following the evidence session, the Committee agreed to further oral evidence. At its meeting today, the Committee will take evidence from—

   • Paul Gray, Director-General Health and Social Care, Scottish Government and Chief Executive, NHS Scotland;
   • Christine McLaughlin, Director of Health Finance;
   • Shirley Rogers, Director of Health Workforce and Strategic Change;
   • Dr Catherine Calderwood, Chief Medical Officer, Scottish Government.

2. The Auditor General’s report contained a number of Key messages which were highlighted in the briefing from the Auditor General for the meeting on 15 November. These are—

   • The NHS in Scotland is not in a financially sustainable position. The overall health budget in 2017/18 was £13.1 billion, a 0.2 per cent decrease in real terms on the previous year. NHS boards struggled to break even in 2017/18, and are increasingly reliant on brokerage from the Scottish Government and on short-term measures. NHS boards made unprecedented savings of £449.1 million but relied heavily on one-off savings. The financial pressures facing the NHS continue to intensify (set out in Exhibit 5, pages 15 and 16) and EU withdrawal will bring additional challenges, including recruiting and retaining staff and procuring vital supplies such as drugs.

   • The Scottish Government published its Medium Term Health and Social Care Financial Framework in October 2018. This is an important step in enabling an open debate about the scale of the financial challenges ahead and the potential options for dealing with the impact this will have on delivering services. Detail on what the framework means in practice is not yet available. The Scottish Government also announced that all territorial boards’ outstanding brokerage will be written off at the end of the 2018/19 financial year and that territorial boards will no longer be required to break even at the end of each financial year. These are welcome steps but for these to have a positive impact, the underlying financial challenges still need addressed and it remains essential that NHS boards develop their longer-term planning.
• Performance continued to decline against the eight key national targets between 2016/17 and 2017/18. Only one key target was met nationally (for 90 per cent of patients referred for drug and alcohol treatment to receive treatment within three weeks), and no boards met all key targets. More people waited longer for outpatient and inpatient appointments. NHS boards need to balance quality of care, performance targets, and financial targets. A continuing focus on meeting targets in the acute sector makes it harder to achieve the longer-term aim of moving more funding and services into the community. In October 2018, the Scottish Government published its Waiting Times Improvement Plan. This set out a series of interim targets and funding to improve waiting times performance.

• The NHS workforce is crucial to the future of the NHS, but NHS boards continue to face significant workforce challenges. NHS boards continued to find it hard to recruit staff in 2017/18, with vacancy rates across key staff groups higher than in previous years. Sickness absence and staff turnover also increased over the past year to 5.4 per cent and 6.6 per cent respectively. We have recommended that the Scottish Government, in partnership with NHS boards and integration authorities should continue to develop a comprehensive approach to workforce planning.

• Changing how healthcare services are accessed and delivered will bring real benefits to patients, NHS staff, and the wider public but the scale of the challenges facing the NHS means decisive action is required. There needs to be an urgent focus on the key elements that are critical to success, including clarity about the scale of the challenge, effective leadership, involving stakeholders in planning and decisions, and clear governance. We have made a number of recommendations relating to these factors in the report (pages 5 and 6).

• Leaders play a crucial role in developing and delivering change but there is evidence that the NHS is struggling to recruit and retain the right people. We have recommended that the Scottish Government, in partnership with NHS boards, should identify why NHS leadership posts are difficult to fill and develop ways to address this. The Scottish Government and NHS also needs to become more open, with much more engagement and information needed about how new forms of care will work, what they cost and the difference they make to people’s lives. Without this, it will continue to be difficult to build support among the public and politicians to make the decisions needed to change how healthcare is delivered in Scotland.

3. The report covers a number of areas that have been of interest to the Committee previously including—
• sustainability of services, and the short-term nature of financial planning and savings;
• clarity of governance of the healthcare system
• the workforce challenges facing the NHS
• variation across NHS boards in performance against national standards.

4. The Committee’s previous scrutiny of the Auditor General for Scotland’s report on the NHS in Scotland 2017 can be found here. The Committee’s scrutiny of the Auditor General for Scotland’s report on NHS Workforce Planning can be found here.

Clerks to the Committee
17 December 2018