OFFICIAL REPORT
AITHISG OIFIGEIL

Public Audit and Post-legislative Scrutiny Committee

Thursday 30 March 2017

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 30 March 2017

CONTENTS

PUBLIC AUDIT AND POST-LEGISLATIVE SCRUTINY COMMITTEE
9th Meeting 2017, Session 5

CONVENER

*Jenny Marra (North East Scotland) (Lab)

DEPUTY CONVENER

*Liam Kerr (North East Scotland) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Monica Lennon (Central Scotland) (Lab)
*Alex Neil (Airdrie and Shotts) (SNP)
*Gail Ross (Caithness, Sutherland and Ross) (SNP)
*Ross Thomson (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Lindsay Bedford (NHS Tayside)
Professor John Connell (NHS Tayside)
Lesley McLay (NHS Tayside)
Andrew Russell (NHS Tayside)

CLERK TO THE COMMITTEE

Terry Shevlin

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Public Audit and Post-legislative Scrutiny Committee

Thursday 30 March 2017

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Jenny Marra): Good morning and welcome to the ninth meeting in 2017 of the Public Audit and Post-legislative Scrutiny Committee. I ask everyone to switch off their electronic devices or to switch them to silent mode so that they do not affect the committee's work.

Before moving on to our formal business, I point out that this is likely to be Gail Ross's final meeting as a committee member. I record my thanks to Gail for her work this session.

Our first item of business is a decision on whether to take agenda items 3 and 4 in private. Do members agree to do that?

Members *indicated agreement.*

Section 22 Report

"The 2015/16 audit of NHS Tayside"

09:00

The Convener: Under agenda item 2, we will take oral evidence on the Comptroller and Auditor General's report entitled "The 2015/16 audit of NHS Tayside" from Lesley McLay, chief executive, Professor John Connell, chair of the board, Lindsay Bedford, director of finance, and Andrew Russell, medical director and deputy chief executive of NHS Tayside.

Before I invite an opening statement from NHS Tayside, I want to put today's evidence session into some context.

We last took evidence from senior officials in December, to seek an assurance on their ability to manage the very serious financial challenges that were facing NHS Tayside. Since then, the picture has worsened in some respects.

In December, NHS Tayside projected an £11.7 million deficit for this financial year, which would be met by loans from the Scottish Government. It did not anticipate any impact on the level of services being provided. The Scottish Government has since confirmed a further £1.5 million of loans for this year, in its words:

> "to avoid the prospect that NHS Tayside would otherwise require to take cost saving action which would impact delivery of patient care".

NHS Tayside has asked the Scottish Government for a further £4 million loan for next year. Indeed, that sum is already included in its draft five-year plan. That would take NHS Tayside's overall loan debt to over £37 million. However, it is not clear whether the Scottish Government will grant the £4 million loan. In the next financial year, £5 million of the £45 million savings that NHS Tayside has to make are classed as "high risk" and £12m has been identified as "medium risk". We do not know what that means for ongoing service provision. In December, NHS Tayside told us that it fully anticipated repaying all Scottish Government loans over five years. Its five-year plan apparently now shows £2.6 million of loans still outstanding at the end of that period.

In December, NHS Tayside told us that the Scottish Government thought that its five-year financial plan was credible. However, we now know that the Scottish Government is asking for independent assurance on the ability of the transformation programme to deliver the change that is required. In February, the Scottish Government told us that NHS Tayside is to receive £8 million annually for the next four years, which

was not in its previous plans. All that is within the context of NHS Tayside also having to make efficiency savings of about £175 million over the next five years.

Finally, we know that senior Scottish Government and NHS Tayside officials met on Monday 27 March and that one of the issues for discussion was whether patients in NHS Tayside could face longer waiting lists.

That is a brief summary of the current position. We will, of course, explore all those issues in depth until we are completely satisfied that NHS Tayside has a grip on the situation.

I now invite an opening statement from Professor Connell.

Professor John Connell (NHS Tayside): I thank the committee for the opportunity to make an opening statement. I know that there are, as the convener has outlined, a number of issues that you will want to cover this morning. My colleagues and I will answer your questions transparently. With that in mind, I will keep this statement brief.

For NHS Tayside, 2016-17 has been a pivotal year and one in which our staff have continued to demonstrate their absolute commitment to high-quality, safe and effective healthcare services for patients, their families and communities. Our financial plan for 2016-17 will deliver just over £45 million of efficiency savings for the whole system. That has been challenging, but our priority for the period has, as always, been to seek to ensure patient safety and the patient experience. In that regard, I assure the committee that our performance on waiting times and the patient experience has been maintained, and in many instances improved, over the past year.

I will give some very brief examples. We have an improved position on our 31-day and 62-day cancer targets and a much improved position on the delivery of alcohol and drug treatments, and we have maintained our position as the highest-performing board in Scotland for four-hour waits in accident and emergency. Indeed, when we compare our position with the other major teaching health boards in Scotland, we are either first or second on 12 of the 17 national standards.

As one would expect, and as the committee has confirmed, we have been in regular dialogue with the Scottish Government health department regarding our forecast outturn for this year and the future. I confirm that, through those discussions, we have agreed to seek further brokerage of up to £1.5 million, which is in line with the forecast that Paul Gray gave you when he appeared before the committee in February. We have worked hard over the past couple of months to ensure that there has been no impact on patient care and patient services, and it is against that backdrop that we agreed to seek the additional brokerage. Our difficulty in fully closing the savings gap reflects on-going pressures, including the challenge in reducing the level of delayed discharges in our system, which lies some way outside our full control, and cost pressures on our prescribing budget.

To put the sum of £1.5 million into context, it equates to 0.18 per cent of our annual revenue resource. That is not to minimise the sum, but to put it into context and to demonstrate the margins with which all health boards operate. We have submitted to the committee our draft one-year operational delivery plan and our updated five-year transformation programme, and we are happy to answer detailed questions on those. We have already acknowledged that we will require the continued support of the Scottish Government, and it is my understanding that Mr Gray has agreed that he is willing to sanction up to £4 million of additional brokerage for the financial year in question, which is 2017-18.

In addition, the board is happy to welcome an assurance advisory group, which will, as has been agreed with the Scottish Government, work with NHS Tayside and will provide challenge, advice and assurance on our five-year transformation programme. We believe that that is a positive step. The wealth of experience of the people in the group, which is led by Sir Lewis Ritchie, whom I have already spoken to, will bring further external perspective to planning and delivery of our transformation programme. Given the scale of the challenges that we face, we acknowledge that the group will bring additional capacity and will support our staff who work hard to deliver day-to-day care and treatment for patients, families and communities.

Lastly, I give the committee my assurance, as I did when I appeared before the committee in December, that the board remains committed to returning to financial stability. I think that I said at that time that that is a long-stage plan that will not be achieved overnight; that remains the case. In addition, I give an assurance on our position in relation to patient care and experience. I would like to place on record our commitment to ensuring that our staff will continue to deliver safe, high-quality and effective care. The people of Tayside should be aware of that.

The Convener: Thank you very much, Professor Connell.

I outlined in my opening remarks some of the financial pressures, loans, brokerage and debt that are facing NHS Tayside. However, just before Christmas, you said in the local press that there would be no impact on patient services. Can you make that guarantee now?

Professor Connell: I can confirm that the financial pressures have not had an impact on patient services. I am happy to give examples; we have not changed services as a result of financial pressures. Clearly, services have to change to reflect pressures including availability of beds, the delayed discharges and the ability to recruit and retain staff. Patient services always reflect those pressures, but they have not been modified as a result of financial constraints.

The Convener: That is the case over the past six months. You made that statement on the front page of the *Evening Telegraph* in December and it is now March, so it is actually less than six months. We are looking at a five-year plan that NHS Tayside has put in place, with no guarantee that all the loans can be paid back. Can you guarantee that, over that five-year period, there will be no impact on patient services in NHS Tayside?

Professor Connell: It would be foolish to give you a five-year guarantee on anything. I cannot account for what our budget will be in five years: it will depend on national and international financial changes. I cannot give you an indication of what Tayside's budget will be, in accurate detail, in five years, but to the best of our ability we will maintain and support patient services, as appropriate, within our financial envelope.

The Convener: What was the timescale for the guarantee that you gave in December?

Professor Connell: The guarantee that I gave in December was that, based on what we were doing at the time and would be doing in the foreseeable future—which, generally speaking, in the function of an NHS board, is one year—we could predict exactly what resource we had to spend and how we would spend it. We will maintain patient services as efficiently and effectively as possible. Patient services will change as appropriate in the light of the national clinical strategy and the document from the chief medical officer, "Realising Realistic Medicine".

The Convener: So, that guarantee was valid for the first year of the transformation plan.

Professor Connell: I do not think that it is appropriate for me to give you a time limit on a guarantee. I am guaranteeing that the board will do its utmost to maintain patient services within the available financial resource.

The Convener: I do not recall whether he used the word "inevitable", but Paul Gray told the committee on 9 February 2017 that patients would have to wait longer for treatment in NHS Tayside. Is that the case?

Professor Connell: It has not been the case.

The Convener: Could it be the case over the next five years?

Professor Connell: The thing that will most likely impact on patient waiting times, I suspect, will be our ability to attract appropriate high-level consultant staff to deliver services. Our biggest waiting time at the moment is in urological surgery. That reflects the difficulty in attracting consultant urologists to Scotland and to Tayside; it is not a financial issue.

The Convener: Could other waiting lists be impacted by the financial situation?

Professor Connell: I will ask my medical director to comment further on that, but my understanding is that, at present, we do not foresee an impact on waiting lists based on our financial situation, although clearly our ability to attract and retain staff and to manage our bed complement will be impacted.

The Convener: Before Mr Russell comes in, I should say that Paul Gray does foresee an impact.

Andrew Russell (NHS Tayside): I reinforce Professor Connell's view that changes to our clinical services will reflect our ability to embrace contemporary clinical practice and an evidence base that says we should offer patients a different range of services with different outcomes. That will not be driven principally by financial concerns, but by our ability to offer the best outcomes within the available resource.

The Convener: Dr Russell, do you think that there will be an impact on patient waiting times in NHS Tayside as a result of the financial situation?

Andrew Russell: I do not see there being an issue that is directly related to the financial position because, as Professor Connell has stated, the determinants of our ability to deliver are around workforce and our being in a position to have consultant staff, in particular, available to provide the interventions that are counted as part of the treatment-time guarantees.

The Convener: Why, do you think, does Paul Gray think patients will have to wait longer as a result of the situation?

Andrew Russell: I cannot speak on behalf of Mr Gray. You may wish to ask for further detail on that from him. I would say that the position that we find ourselves in is one in which the availability of the workforce will be the principal determinant of our ability to deliver our service, and that will focus on outcomes in particular.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I have read through the one-year and five-year plans and I have to say that there are not a lot of solid indications as to how you are going to achieve the savings that you

have peppered the document with. It is more a declaration of intent than a pathway to achieving what you are looking for.

Professor Connell: Do you wish me to comment on that, or is that a question?

Colin Beattie: I would be interested to hear your views on that.

Professor Connell: The five-year plan has, by necessity, to be a long-term vision. I do not think that any health board in Scotland could give you a five-year plan that had very detailed information on delivery of services costed over a five-year timescale. A one-year plan is different, and I believe that we have, in our one-year plan, outlined the key areas in which we see savings being made.

09:15

Colin Beattie: You have outlined the key areas, but you have not gone into them in any depth. I am still none the wiser as to how you are going to achieve the efficiency savings to which you refer in each area. There are only declarations of intent.

Professor Connell: As a board, I think that we have struck a balance in producing a plan that is not so detailed as to be unreadable but which indicates where the savings will be made. I ask my chief executive, Lesley McLay, to comment on the granular detail of where those savings will be.

Lesley McLay (NHS Tayside): Our plan is a draft plan, which we will submit formally to the Government tomorrow. The plan has been built up through the services: through our clinical leads, general managers and professional leads. Underneath each of those service areas, there are detailed plans.

It was key for us in the one-year plan to get the planning principles right. Those planning principles have determined the risk assessment that you see in the plan, with areas defined as “high risk”, “medium risk” and “low risk”. As a board, we are discussing with the Government our high-risk areas in particular, and we are expecting to work closely with the assurance advisory group on the detail of those areas.

In summary, we have detailed plans that sit underneath each of the service areas. We recognise the importance of working with the Scottish Government and the assurance advisory group, which will support us in more granular discussion around the high-risk areas in particular. We intend to publish the plan formally after that.

Colin Beattie: Given the undoubted seriousness of the matter, the committee asked for detailed plans back in December. What you have given us are—as you said yourself—headlines.

Lesley McLay: Yes.

Colin Beattie: There is no way that we can look at the plan and say, “Oh well, you have a decent plan in place that is going to work.” We cannot do that—the plan just does not allow for it. You refer to it as a draft plan. Whom have you consulted on the plan?

Lesley McLay: The plan has been put together with our front-line staff, managers and clinical leads in the organisation, and it reflects the strategies that the board has already approved, so we have detailed plans for older people, mental health, planned care and unscheduled care. What you are seeing is a summary of the areas in which we will be delivering in 2017-18. I assure you that there are detailed plans sitting underneath the overall plan. Because it is a draft plan, and because we recognise the importance of the risk assessment, especially in the high-risk areas, we will do further work jointly with the Scottish Government. Our intention in our board discussions over this month has been that we will then formally bring the plan back to our main board meeting.

Colin Beattie: You mentioned consultation of staff. Have you consulted the unions and other stakeholders?

Lesley McLay: Yes, indeed.

Colin Beattie: Do they support the plan?

Lesley McLay: If I may, I will pass the question to our chairman, who had a conversation about the plan yesterday with our area partnership forum.

Professor Connell: Yes. The area partnership forum has considered our financial framework twice in the past month. In the first instance, the forum considered the financial framework against which the plan has been developed for the next year. It is aware of, and has approved, the notion that we have to find savings across the board, in our acute sector and in our partner integration joint boards, of the order of magnitude that is shown in the plan.

The draft plan that you see now was looked at by the area partnership forum at its meeting yesterday, which I attended. The forum jointly agreed that it wished to work together in partnership to produce the final version of the plan, which will be agreed finally by the Scottish Government. It is a partnership document.

Colin Beattie: Would it be possible for the committee to see the more detailed plans that lie underneath the draft plan? The situation is very serious, and we have to ensure that we have understood fully the position that you are in.

Professor Connell: Yes.

Lesley McLay: Yes. It should be recognised that the plans are still in draft form. We recognise the importance of the role of the assurance advisory group and the challenge that it will bring to the plan. That process will be happening over the coming weeks, but the draft plans are there, and we would be happy to support the committee by providing that information.

Colin Beattie: In response to a question from the convener, you said that patient care would be unaffected by this work. However, your one-year plan says:

"For our patients this means removing any elements of their care pathways that do not add value to their experience or outcomes."

Will you give me an example of that?

Professor Connell: I will ask our medical director, Andrew Russell, to answer that. We are clear that our pain pathway is an area of our patient service where there is inappropriate cost. That might be a good example to cite.

Andrew Russell: I am happy to give you additional detail on that, Mr Beattie. When it comes to how we offer services to people with pain in Tayside, we are particularly dependent on the use of medicines and the use of a tertiary service around our pain clinic. If we compare ourselves with other systems, we see that a greater range of alternatives to the use of medicines are available in the community. As we move forward, we will put less emphasis on the use of medicines and more emphasis on the use of some of the alternatives.

Colin Beattie: In the plan, you talk about

"removing ... elements of their care pathways".

You do not talk about moving to alternative medicines in order to save money. Will you give me an example of what you would remove?

Andrew Russell: We would remove elements of the prescribing that we do not think add to the value and outcome levels in the patient's experience and we would seek to invest in other areas of that pathway in order to bring about better outcomes.

Colin Beattie: You would remove drugs. Are you overprescribing at the moment?

Andrew Russell: We are not overprescribing, but we have less of a focus on some of the alternatives to the use of medicines than some of the other health board systems have. The evidence shows that a much broader set of interventions beyond the use of medicines produces the best outcome for people's quality of life and their ability to function and to return to their place of work. Historically in Tayside, we have had a particular focus on our pain pathway working with our tertiary pain service.

Colin Beattie: I am still not clear about the meaning of

"removing ... elements of their care pathways",

but we will park that for the moment.

Do you benchmark your costs against those of other NHS boards? Do you track that? There is no mention of that in your plan.

Professor Connell: Absolutely. We have cost comparisons and benchmarking across a range of areas. Given that we are talking about prescribing, that might be a good area to stick to. We have accurate, updated benchmarking on our prescribing costs across a range of indicators of chronic, complex disorders, such as diabetes, chronic respiratory disease, asthma, atrial fibrillation—irregularity of the heart—and high blood pressure. I ask our medical director to expand on the benchmarking that we have in place.

Andrew Russell: We can now look at the six most common chronic disease conditions in Scotland from a cost perspective and see the cost of the medicines that are prescribed to each patient, rather than a nominal amount being allocated, as was the case historically. We also know that the prevalence—the level of disease in the community that is being treated at any one time—differs across Scotland. In Tayside, in 12 of the 16 areas, we are at the top end of the levels of disease that are being treated in our communities. We benchmark that against the chronic disease registers that are made available for the quality and outcomes framework from general practice.

Our cost per treated patient in those chronic disease areas is comparable to—in fact, it is lower than—the costs in the majority of Scotland. However, when it is taken into account that we have more patients requiring treatment in those areas, we have significant cost pressures. If we were to have the same prevalence of those diseases as the rest of Scotland, that would take off £3 million from our prescribing budget.

Colin Beattie: There is nothing in your plan that convinces me that you are going to reach your target, so I am quite keen to see more detailed plans. The indications are, as the convener has said, that the Scottish Government also has reservations about whether you can achieve what you propose—indeed, it is proposing to have an independent review, which would be quite a prudent thing to do at this point. Has the review started?

Professor Connell: No. The Scottish Government agreed the members of the review panel with us on Monday. The members of the

review panel were contacted on Tuesday. I spoke to Sir Lewis Ritchie, who will lead the panel, this morning. I spoke to Steve Logan, the chair of NHS Grampian, yesterday afternoon. Paul Hawkins, who is the third member of the panel, has been in contact with our chief executive. Lewis Ritchie anticipates that the panel will probably meet for the first time early next week, and it will then begin to engage with NHS Tayside.

Colin Beattie: I cannot remember—is there a target date for completing the review?

Professor Connell: Three months.

Colin Beattie: Three months. We will await the outcome and hope that we get more detailed information that will give us some reassurance on the plan, which at the moment is fairly weak, as far as I can see.

The Convener: In addition to the assurance group that the Scottish Government has put in place, has the Scottish Government given NHS Tayside any extra managerial support to assist you with the work that you are doing?

Professor Connell: Yes. In recent weeks, we had an independent review carried out by Dr Gregor Smith, who is the deputy chief medical officer and a general practitioner with an expertise in prescribing. He has worked with our prescribing management group and has looked at our prescribing costs. He has submitted a report to Paul Gray on that, which I have seen.

The report concludes that our analysis of our cost pressures is correct. He identifies that we have areas of high cost that are accounted for by what the medical director said was increased disease prevalence, where our cost per patient is often lower than the benchmark. He confirmed our view that we have areas where we need to contain costs, particularly around chronic pain, and that is an area that we will focus on. He also confirmed our view that we need to institute a Tayside formulary to constrain the choice of drugs available to general practitioners, and that is work in progress.

The Convener: In addition to Gregor Smith's review of prescribing, has the Scottish Government seconded any staff to NHS Tayside to support you?

Professor Connell: I will ask our chief executive to answer that.

Lesley McLay: Over the past 12 months, we have had support in the form of subject-matter expertise from NHS National Services Scotland. We have had some programme management support for our transformation programme and individuals have come into specific programmes such as our catering programme and the out-patient work that we are doing. We have been fortunate and we have welcomed that opportunity. It has created additional capacity for our staff, who are delivering the front-line job as well as doing the planning and redesign.

The Convener: Has the Government seconded anyone at management level specifically to support the work that you are doing?

Lesley McLay: No.

Ross Thomson (North East Scotland) (Con): I have a supplementary to the convener's line of questioning on the evidence that we received from Paul Gray.

On waiting lists, Paul Gray advised this committee that reducing treatment rates was one of the contingencies that NHS Tayside had raised with him as part of improving its financial situation. I will quote what he said to the committee:

> "That is the issue I want to discuss with the board: whether and how it will deploy some of the contingencies. Some might be appropriate, and some might not. I just want to be sure about that."

When the convener asked whether that would mean longer waiting lists, he replied:

> "Well, yes. Let us not beat about the bush—of course it would".—[*Official Report, Public Audit and Post-legislative Scrutiny Committee*, 9 February 2017; c 17-18.]

Is reducing treatment rates a contingency that you have discussed with Mr Gray? What other contingencies are you looking at to help to improve your financial situation?

Professor Connell: We did discuss with Mr Gray whether we could control costs in the short and longer term by taking actions that would result in longer waiting lists. We felt that that was inappropriate, and he agreed. Therefore, we did not take those actions. Those actions would include closing theatres, reducing operation availability time and making patients wait longer for necessary surgery. We believed that to be inappropriate, and we still do. Our challenge is to find ways of saving money without impacting on patients in that way.

I do not know whether my chief executive has anything to add.

Lesley McLay: The only other point that I would make is that, as can be seen from our 2016-17 plan, over the past three years NHS Tayside has invested money in putting mobile theatre capacity on to the site at Ninewells hospital. We were trying to bring all our work in-house and take out our private sector work, and we did that. The cost of that to the organisation is somewhere in the region of £1.7 million.

That was a commitment that we made in 2016-17, and it has allowed us to hold our performance, particularly in relation to some of the access

targets. Action that would have increased waiting times was an option, but we were not prepared to take that option.

09:30

Ross Thomson: Obviously, significant savings have to be made. I am trying to tease out exactly what the negative impact will be on the quality of care and performance as a result of that. I am trying to find out what alternatives and contingencies you have discussed with Mr Gray. Could you enlighten the committee as to what those are?

Professor Connell: I will start off and will then pass over to Lesley McLay. I make the observation that other health boards have made decisions to make savings that have impacted on patient waiting times. Our out-patient waiting time has been held stable, whereas other health board waiting times have gone up substantially. There are decisions that health boards can make that impact on patients, but we chose not to impact on patients.

There are other savings that we can make, particularly around day-case surgery and making surgical patient access more efficient. I ask Ms McLay to add to that.

Lesley McLay: That is a key feature of our 2017-18 plan. Mr Beattie talked about benchmarking. We have been looking at the productive opportunities in the organisation, working closely with Scottish Government colleagues and using the discovery tool, which is a national tool that allows us to look at the performance of every other board in a range of areas. In our planned care service plans for 2017-18, we have set targets to increase day-case surgery. There are also areas around pre-operative stays where we need to improve. That is a productive opportunity, because it means that people come in on the day of surgery, which allows us to reduce our bed days and deal with the pressure on bed numbers and so on. In 2017-18, we have a number of opportunities that will drive efficiencies without impacting on quality of care.

Ross Thomson: I suppose that I am looking for the guarantee that the convener was looking for, and I am following up on Professor Connell's remarks. We are being told that, despite the significant savings that have to be made and the significant amount of money that has to be paid back in debt, there will be no impact on patient care and quality of care. Is that what you are saying to the committee and the public today?

Professor Connell: Can I perhaps expand on that? As far as is within our power—

The Convener: As much as possible, can we have a direct answer to that question?

Professor Connell: Yes, I am going to come to that question.

As far as is within our power, we will give that guarantee, but there are factors that are outside our control. At present, we have 60 blocked beds in Perth and Kinross alone. That means that we cannot have access to surgical beds for patients in the way that we would like. If those patients were not in NHS beds but in the community—as they should be—we would be able to deliver much more efficiently on our financial targets and patient waiting times. It is that factor, rather than finance, that constrains us.

The Convener: I take it that your implication is that that is an issue for Perth and Kinross Council and the IJBs.

Professor Connell: That is an issue that has to be solved in partnership.

The Convener: Yes.

Monica Lennon (Central Scotland) (Lab): It appears to me that NHS Tayside is still very much in financial distress, but we have heard in evidence today that patient experience and waiting times remain fine.

I want to return to staffing, which Colin Beattie touched on earlier. At the committee's meeting in Dundee in December, we heard from local trade union representatives, and they did not give us a pretty picture—they raised some serious points. Professor Connell, you said that the area partnership forum was consulted yesterday and that everyone is on board with the plans, but there will be pressure on staff to try to achieve the transformation that you say is vital. Will you give us more detail about the consultation and say what partnership actually looks like on the ground? Who is on the area partnership forum? Did anyone at all raise any significant concerns, echoing what we heard in December about low morale?

Professor Connell: I will pass over to Lesley McLay to give you a full answer on that, but I was at the area partnership forum yesterday, so I know that staff partners are obviously concerned about the impact of the financial plan; what it will mean for staff, their jobs and their ways of working; and how the savings will be delivered. The partnership forum agreed that it would be developed with them jointly. As our chief executive said, the plan is in evolution. It will be developed as a partnership and it will be owned by the partnership forum.

On consultation and relationships with our staff partners, I will pass to Lesley McLay.

Monica Lennon: I am sorry to interrupt, but when the area partnership forum met yesterday,

was that the first time that it had seen the draft plans?

Professor Connell: That was the first time that it had seen that document; the board saw it for the first time on Monday. However, the partnership forum had seen the financial framework and the financial underpinning of the plan earlier in the month.

Lesley McLay: Key to the success of the plan is the leadership that we get from not just our clinicians and managers, but our trade union partners. A number of months ago, the board took a further step to enhance that by making core members of our senior leadership team members of the NHS Tayside area partnership forum and the area clinical forum. That was done to move us forward, not just in terms of having our area partnership forum monthly meetings and our consultation, but to get our senior leadership team into the heart of the build and the process of looking at the performance of the organisation. I can already see the benefits that we are getting from that. It is important to own the plan, rather than to just get it to a point at which we consult on it. We will continue to build on that.

Monica Lennon: Let us look at some of the detail. On page 40 of the five-year plan, you mention

"extended hours of working for additional clinic capacity at weekends/evenings."

Do you think that that can be managed with your current staffing complement? Have unions raised any concerns on that particular point?

Lesley McLay: Sorry, did you say page 40 of the one-year plan?

Monica Lennon: Page 40 of the five-year plan.

Lesley McLay: I apologise; my copy of our five-year plan only goes up to page 32.

Monica Lennon: The issue is in relation to extended hours of working in order to increase clinical capacity at weekends and evenings. What have the trade unions said on that point? Are you confident that you can manage that with your current staffing complement?

Lesley McLay: Seven-day working has been a key feature for the board over a number of years. We have increased our access to diagnostic services so that patients get timely access at weekends. In particular, over the winter months, our allied health professional services develop rosters so that staff work over a seven-day period.

That development is core for the board and we will continue to take that approach, but we will do full consultation with our staff for any such changes, which would be made in partnership. There are a number of areas in which we strive to provide provision over seven days.

Monica Lennon: On page 16 of the five-year plan, you say that

"'more of the same' in relation to our staff cost base is no longer a viable position"

and that that will involve a

"reshaping of the size and grade mix of our workforce".

Does that mean cuts to staff numbers?

Lesley McLay: No, it does not. I talked about that at the committee's meeting in December. We recognise that our workforce base is higher than you would expect, but we are clear that that is driven by the number of hospital sites, in particular—I think that I referred to the fact that we have 26 hospital sites at that meeting.

Through natural attrition—either retirements or people leaving as a result of the introduction of technology—there are ways in which we can reprofile the workforce. We are doing that with the workforce. One example is that, from the beginning of April, through the work that we have done this year, we will be able to change our theatre workforce. Recruitment to theatres is a national challenge across all health boards, but we have worked with our staff to reprofile roles. We have created a band 4 role that did not traditionally exist, which allows staff with other skill mixes to focus on particular duties. In some areas, the redesign can result in the creation of new roles.

NHS Tayside also has a strong apprenticeship programme across a whole range of services. We are looking in an innovative way at how we can reprofile and make sure that the staff with the right qualifications are doing the right job.

Monica Lennon: How many apprentices do you have?

Lesley McLay: Twelve.

Monica Lennon: How many do you expect to have by the end of the five-year transformation plan?

Lesley McLay: I do not have that information available to me, but I can certainly get back to you.

Monica Lennon: What will the reshaped workforce look like in five years' time in terms of numbers? Will the numbers increase, decrease or stay the same?

Professor Connell: It would be difficult to predict what the shape and size of the workforce will be in five years, partly because of the change with regard to health and social care integration. Clearly, much more care will be delivered in the community, with a different type and grading of staff. I therefore cannot tell you now how many

staff will be employed directly by NHS Tayside and how many will be employed in the care sector through third sector or other employers. I would not anticipate there being a major change in the number of staff employed in core services, but there might be a major change in the type of staff because of changes in technology and medical practice. So, it would be foolish for me to say that there will be no change in the total number of staff—it might be higher or it might be lower—and the distribution of staff between hospital and community will undoubtedly be different.

Monica Lennon: In previous evidence sessions, the committee has looked at the 39 per cent rise in spending on agency staff, which I think you will all accept is extremely high. I think that Lesley McLay said previously to the committee that the number of nurses in your nursing bank had increased from 800 to 1,200. Can you give us an update on what the profile looks like now and whether the use of agency nursing has increased?

Lesley McLay: I am happy to do that. Our nurse bank numbers have increased. I think that over the past week we have gone up to having about 1,300 nurses in our bank. However, we have instigated a survey of nurses who are recent leavers and we have been able to secure a return-to-practice accreditation programme with the University of Dundee and are looking to target people to get them back into nursing practice. We are therefore not resting on our laurels in terms of the number of nurses that we have at the moment and are continuing to increase that number.

We have been and still are a relatively high user of non-contract agency nurses, but I can advise the committee that our overall use of agency nurses in 2016-17 is down 22 per cent on what it was in 2015-16, which has given us an efficiency saving of just under £1 million. So, through better recruitment into our nurse bank and through better rostering policy and deployment, we have been able to reduce our reliance on agency nurses. It is a key feature of our 2017-18 plan that we will continue to look to reduce our reliance on non-contract agency nurses.

Monica Lennon: What lessons have been learned from the circumstances that led to that huge spike in spending on agency nursing? Surely that did not happen just by accident.

Lesley McLay: It has been quite complex to understand that when tracking back, because until 2013 we were low users of agency nursing. There was therefore an increase over three years. Part of that undoubtedly reflects the challenges in nurse recruitment. We are working hard to understand the flexibility that our staff want and are looking to see how we can deploy employment contracts for them that are as family friendly as possible. We must also recognise the age profile of our workforce, because quite a high proportion of them are going into the 50 to 60 age group. We are looking to see how we can create a work plan for them in their final five years to support their continued employment. We will continue to work hard on all that over the next 12 to 18 months.

Monica Lennon: So you think that you now have the circumstances that I referred to under control.

Lesley McLay: The situation is definitely improving, and the 22 per cent reduction is significant, but I am not complacent about our position. Our overall use of agency nursing has reduced and it is now about 10 per cent of the overall use of agency nursing in the national health service in Scotland. Is that correct, Lindsay?

Lindsay Bedford (NHS Tayside): Yes. Last year, we accounted for about 23 or 24 per cent of the spend in Scotland on non-contract agency nurses, but we expect our figure for this year to be about 15 or 16 per cent. However, if we look at the month of January alone, we can see that Tayside had 10 per cent of Scotland's spend. So, it is clear that the action that we have taken since December has been changing that pattern of use.

Monica Lennon: You have previously talked us through the savings that will be realised through the disposal of surplus assets, and you have talked about what will happen over time as hospitals close. I see from the update that we have received that you have managed to sell a couple of properties since we previously met you, including the Murray royal hospital for £550,000. Is that what you expected to get for that property?

09:45

Professor Connell: That is a question for Mr Bedford, I think.

Lindsay Bedford: That is lower than the original estimate from a couple of years ago.

Monica Lennon: Why was that, Mr Bedford?

Lindsay Bedford: We all recognise that all property sales are open to market forces. As with all property sales, the Murray royal sale was complex. It had a historic grade A listed building on it. The significant investment that developers will probably have to make limits the market for such sites.

Monica Lennon: I understand the pressures on developers and development finance, but what did you expect to get for that property, taking all that into account?

Lindsay Bedford: The original estimate was around £1.5 million.

Monica Lennon: Okay. I am not local to Tayside and I do not know the site but, when I looked at it on Google last night, it seemed to be rather large. I think that it is around 21 hectares. It seems that someone got a bargain.

When we spoke to Paul Gray, it was confirmed that any money that you get from those properties will not be clawed back centrally. Have asset sales been used to offset brokerage so far? How much has that amounted to?

Professor Connell: Again, I think that Mr Bedford is best placed to answer that question in detail.

Lindsay Bedford: At this stage, asset sales have not offset any of the brokerage. We have used the money to assist the in-year financial position. In this financial year, probably close to £2 million will assist the financial position to get to the—

Monica Lennon: Was that agreed with the Scottish Government?

Lindsay Bedford: It was. We put that proposal to the Scottish Government for the next two financial years, as well.

Monica Lennon: Okay. So any future asset sales in the next two years will not be used to offset the brokerage.

Lindsay Bedford: That money will be used to assist the delivery of the overall efficiency savings.

Monica Lennon: Okay. Thank you.

I have a final question. In the spirit of transparency—you touched on that at the beginning, Professor Connell—did the panel receive any coaching in advance of today's meeting from any external advisers?

Professor Connell: No.

Monica Lennon: But you did last time.

Professor Connell: We took advice. I would not have called that coaching.

Monica Lennon: Okay. Thank you.

The Convener: I want to ask about the high-risk efficiencies that are identified in the financial plan for 2017-18. The one-year plan says that you will fall £4 million short of your savings target. Professor Connell, you have already indicated that Paul Gray has said that he might be willing to pay that. However, you have also stated that £5 million of your savings are high risk. What does that mean?

Professor Connell: Again, I will pass that question to Mr Bedford. However, an overview is that high-risk areas are often ones that we think are not fully within NHS Tayside's control in respect of managing the expenditure. Part of that would be the impact of delayed discharges, where we do not have the ability to deliver on that absolutely on our own. Mr Bedford will give the committee further details.

Lindsay Bedford: There are two or three components of the high-risk initiatives. We touched on prescribing earlier. We are implementing initiatives, but we recognise that there is a risk in implementing them in full in 2018-19. That is not to underestimate the amount of work that is going on. Members will be aware that, when we spoke in December, we were pursuing five key actions. The revised formulary will come into place on 20 April, and we will probably need time to understand what its impact will be. Professor Russell might wish to comment further on that. Prescribing is one element of the high risks.

The second element is the level of agency costs, which has been mentioned. The Scottish Government expects us to identify ways of reducing non-contract agency spend by 25 per cent in our local delivery plan. We are keen to stretch that further in Tayside to lessen the impact of non-contract agency costs on the overall system. We recognise that that may be inhibited by recruitment challenges and some of the pressures on the service. That is another element of the high risk.

The Convener: I can see the breakdown, Mr Bedford. Prescribing accounts for nearly £2 million of the high-risk savings. My question is not about where the breakdown comes; it is whether "high risk" means that you are unlikely to make those savings? Presumably there is a risk that you will not make those savings and that is what "high risk" means. What would happen if you did not make those savings?

Lindsay Bedford: As with any plan at the start of a financial year, there is an expectation that the risk will move from high to medium to low as actions are taken in the individual efficiency programmes. For the high-risk elements, we recognise that the actions are not entirely within our control.

The Convener: The biggest chunk is £1.9 million on prescribing. That is completely within your control, is it not?

Professor Connell: The majority of prescribing costs are in primary care.

The Convener: Indeed.

Professor Connell: Primary care lies within the control of the IJBs.

The Convener: Right, okay.

Professor Connell: We work closely with the IJBs—we have a prescribing management group, but it is still a partnership. I will ask Professor Russell—

The Convener: Primary care only fell under the jurisdiction of the IJBs very recently. Until about a year ago, it was part of NHS Tayside and prescribing policy was presumably led by NHS Tayside. Are you saying that you now have no control over general practitioner prescribing?

Professor Connell: I am not saying that, but I am saying that there is now a partnership in place and we have to work within the constraints of that. I will pass to Professor Russell—

The Convener: Does the partnership with the IJBs increase the risk for NHS Tayside's budget?

Professor Connell: It undoubtedly does, in terms of our ability to have delayed discharge patients moved out.

The Convener: Does it increase the risk for prescribing as well?

Professor Connell: I will pass that to Professor Russell.

Andrew Russell: I do not see a specific risk with regard to prescribing and the new arrangements that the convener identified.

The Convener: I do not think that I identified that—I think that it was Professor Connell.

Andrew Russell: I can give a specific example that might help us to understand some of the high-risk elements. There is a specific medicine that is used for cholesterol, which should be used as a third or fourth-line medicine. When that medicine has been looked at elsewhere, about 25 per cent of patients have been found to be on that medicine inappropriately. We have used that as our assumption. However, we have reviewed 1,200 patients and found that less than 10 per cent of them are getting that medicine at the first or second-line. The risk is around the fact that we have taken planning assumptions from experience elsewhere and our local experience may or may not reflect that—that is why that is a high-risk element.

The Convener: Okay, but do you agree with Professor Connell that the new governance structure with the IJBs makes the saving of £1.9 million a high-risk saving?

Andrew Russell: I will let Professor Connell clarify exactly what he meant by that. From my perspective, I do not see the new arrangements impacting directly on that.

Professor Connell: My comment was principally in relation to late discharges. The IJBs have a key role to play in helping us to move patients from acute hospital sites into the community.

The Convener: With respect, Professor Connell, you said that GP surgeries have now moved to IJBs.

Professor Connell: That is true.

The Convener: That was in response to my question about the high risk.

Professor Connell: I apologise if I misled you—I did not mean to. There is no doubt that primary care is now within the IJBs, and the primary care prescribing budget lies within the IJB budget, so the saving that is set against prescribing within family health prescribing is against the IJB budget. Therefore, we need to work in partnership with the IJBs to achieve that saving.

The Convener: You said that you do not have complete control over that, because it is within the IJBs. However, it is within your budget that it becomes a high-risk saving. I think that you are saying that the governance structure is making NHS Tayside budgets more precarious.

Professor Connell: I will ask the chief executive to comment on that, too. There is undoubtedly an added complexity. We now have three IJBs, with three separate budgets, which are derived from NHS Tayside and the local authorities and therefore the governance is more complex than it is for a single unitary health board.

Lesley McLay: I do not disagree with that point. As you mentioned, convener, we are just closing out year 1 of the new governance arrangements. Our one-year plan shows that our planning principles are that we will work as a whole system. Our transformation programme is a whole-system programme, and that crosses all the services that have been devolved to the integration joint board partnerships. There is now a layer of complexity that we need to work through.

The Convener: There are no savings identified from regional working opportunities, but you will have read in *The Courier* yesterday about the situation regarding the exchange of information between NHS Fife and NHS Tayside and the fact that there is a lot of duplication in that process. I presume that such duplication is a cost to NHS Tayside, so why is that not identified as a saving?

Lesley McLay: I am not sure about the specifics of the duplication that you refer to, but we are not reflecting regional working at this stage because of the maturity of the regional plans. There will be a big focus this year on building a regional delivery plan. We are working collaboratively with both the north of Scotland boards and the boards in the south east, too. That development is emerging. It would be high risk at this stage if we were to include specific initiatives

with the high level of confidence that we would look for to deliver efficiencies in 2017-18.

You will note that there is a section in our service plans that talks about the regional or national perspective. That is there to reflect some of the national initiatives or reviews that have been concluded, such as the national burns review, which will go to implementation over the next six to 12 months. There are initiatives that come through at national and regional level that will feature in our plan, but they are not concrete enough for us to have confidence to take efficiencies from our budget.

The Convener: You can identify big savings but every small saving makes a difference, particularly given the situation that NHS Tayside is in. I hear from constituents that there are cost savings that can be made. For example, Action on Hearing Loss has a project to fix people's hearing aids in the community, yet NHS Tayside has refused to fund that this year, despite the fact that independent evidence projects that the scheme would make £87,681 of savings for NHS Tayside's audiology department. Why are such proposals being blocked when independent evidence shows that savings can be achieved? I can share AHL's paper with you.

Lesley McLay: I would be more than happy if you did that. Our service plans are built up from our clinicians and senior managers in each of our specialist areas, so I do not have the detail on that, but I would be happy to look at it.

Lindsay Bedford: As we touched on earlier, we have to submit a draft local delivery plan by tomorrow, but the fact that it is a draft plan recognises the regional planning and delivery of services work that will go on. We have been asked to submit final local delivery plans in September this year, in which regional planning and delivery need to be more fully developed. We will bring forward more aspects as part of the plan, but whether those will result in any cash-releasing savings in 2017-18 will become clear over the next six months.

Alex Neil (Airdrie and Shotts) (SNP): In annex B of the committee's paper 1, Paul Gray says that

"there has never been a proposal to create a for-profit agency within NHSScotland"

to deal with agency nursing. However, that is not quite accurate. When I was Cabinet Secretary for Health and Wellbeing, the chief executive of NHS Grampian was working on a project to bring the organisation of agency nursing in house, given the cost of agency nursing and some of the big profits made by outside agencies, which he felt would be better reinvested in the health service, rather than going into the pockets of the agencies' shareholders.

As the former cabinet secretary, I want to put it on record that we are not questioning the clinical performance of NHS Tayside—I certainly would not question it. For many years, the clinical performance of NHS Tayside, particularly in areas such as accident and emergency, has been one of the best in Scotland. This morning, we are talking about its management of resources, particularly financial resources. One of our concerns is to ensure that its clinical performance is not adversely affected by how we manage that particular problem.

10:00

I turn specifically to the five-year plan. An objective of that plan—the key objective, in some respects—is for NHS Tayside to repay its brokerage to the Scottish Government and to make significant savings. If we add those two figures together, it means that, over the next five years, in effect you have to make efficiency savings of £210 million. By any standard, that is a substantial challenge.

When I read the financial projections in the five-year plan, I thought that they had been written by Mystic Meg, because there was a sense of your saying, "Let's put our thumb in the air and hope for the best", but I did not see evidence of a strategy to get to £210 million. I accept that, because you do not know your budgets for a period of that length, it is not always possible to be absolutely precise, but that should not stop other things happening. I will go on to that in a minute, but first I would like to clarify a couple of specific issues.

Professor Connell, in your opening remarks—or in answer to an earlier question—I think that you said that the savings amounted to about 1.8 per cent—

Professor Connell: That should be 0.18 per cent. The £1.5 million additional brokerage for 2016-17 was 0.18 per cent of our revenue resource limit.

Alex Neil: Right. However, over the five-year period in the plan, there are actually two figures. One is:

"Over the five years of the plan, approximately £210.0 million of efficiencies are identified as being required. This equates to 5.8%"

of the revenue limit. The plan then goes on to say:

"This savings target incorporates over the five year plan close to 1.3% ... to be returned to"

the Scottish Government

"to repay the ... brokerage".

Over the five years, we are talking about 5.8 per cent of the revenue budget—you do not know precisely what the revenue budget will be; that is

your estimate—that will be required to repay the brokerage to the Scottish Government and to make the savings that you need to make. Is that right?

Professor Connell: Yes.

Alex Neil: Okay. The second point that I want to clarify is on page 30 of the five-year plan. It is a bit of gobbledygook that I do not understand, unless I am missing something. It says:

"In delivering on this agenda a focus on delivering a stepped change in mindset and focus is required that will see the organisation transform."

How do you focus on your focus?

Professor Connell: We have to hold up our hands and say that that should have been written better. There is a redundant "focus" in that sentence.

Alex Neil: Right. You can see why we are a bit sceptical about the plan. I picked that as one example; there are many others.

I want to raise two specific points about the plan. Like Mr Beattie, before I came into the Parliament, I spent a lifetime writing business plans for big and small organisations. The first thing to do in writing any business plan is to forecast demand for the business's services. Without a proper forecast of the demand for services, you do not know what you are going to deliver. These days, with all the software that is available, forecasting—in the health service, particularly—can be quite accurate. Where is the forecast here? Can we have the forecast for demand for your services over the next five years?

Professor Connell: In brief, we have that. We have a clinical strategy for five years, which looks at the demographics of the population, the anticipated shift within that regarding ageing and movement within Tayside, disease prevalence and demand for service. Our clinical service strategy is built around anticipated demand and the anticipated change of service from the acute sector into the community. That is not embedded here, within the five-year plan, but it is in a sister document.

Alex Neil: It would be very helpful if it was embedded. In looking at the veracity of a plan, the starting point is the veracity of the forecast. It would be helpful if we saw that, because we would then know what services you have to provide to meet the needs of your population. If we could get a copy of the forecast that would be extremely helpful.

I fully understand that you do not know your precise budgets beyond next year, but are you doing scenario planning? Take, for example, the totality of comparative prescribing costs across the board under acute services, community services and so on. I would have thought—and, to some extent, you have recognised—that if you were able to be as good on prescribing as the best board in Scotland, you could save a significant amount of money. That is where we come back to the forecast of demand in your area.

It is not in the plan, but are you doing any scenario planning on whether you can get to a certain stage in terms of prescribing and the more efficient use of staff and agency staff, including whether you could use fewer locum doctors, who are expensive, and instead have contract doctors who permanently work for NHS Tayside?

Professor Connell: I ask the chief executive and Mr Bedford to say what modelling we are doing.

Lesley McLay: Mr Neil is absolutely right. Planning of that level of detail is going on, particularly with regard to health and social care partnerships and the acute sector services that the board manages. I have four chief operating officers, and they are working as a collective.

Planning is evident in the health and social care partnership plans on the reduction of emergency emissions and, as we have talked about quite a bit already, on delivering the 72-hour standard of patient wait time, with which those who are clinically fit are discharged to the appropriate location within 72 hours.

The IJB partnerships think that they can reduce the number of emergency admissions by X with home support and their new home care infrastructure and community infrastructure. That allows us to look at what that will mean for the bed base in the likes of Ninewells or Perth royal infirmary and how we can redesign the bed base. Part of that will be about reducing the number of beds and having the ability to transfer moneys out to social care.

We are looking at emergency admissions and the impact on how we could redesign, and we are looking at length of stay—we have 119 patients just now who are clinically fit but are in an acute, or mental health or learning disability in-patient bed. If that issue was not there and we were delivering on the 72-hour target, how could we develop and deliver advanced services?

In the planning principles in the one-year plan, for the first time I have included a statement that talks about the delivery of the reduction in emergency admissions. We are quite early on in that journey, but the newly formed partnerships and the integration of health and social care will allow that to mature. The reduction in the number of occupied bed days will allow us to take costs out of infrastructure, some of which is ageing estate, and redistribute that money. There will be

efficiencies there and we will be able to enhance community and primary care. The situation is definitely evolving.

Alex Neil: For the five-year delivery plan to have credibility when one reads it, that kind of scenario planning, which should lead to a strategy in each area and an overarching strategy, needs to be in it. To be fair, I have the same criticism of the national so-called delivery plan. It is not actually a delivery plan, because it tells us where we want to get to but it does not tell us how we will get there. We will not get there by jumping on the number 9 bus in Dundee.

At the moment, the plan does not tell us any of that. Three or four years ago, we could have written a plan about where we want to get to, but the issue is how we will get there. We have not managed that to date. What are the benchmarks for measuring progress in three, four and five years' time? The sum of £220 million is a lot of money to save.

My final question is on the assurance group. I repeat that there is no better person than Sir Lewis Ritchie to lead that group and that I have the highest respect for him. However, with all due respect, the striking thing about the three-person review group—apart from the fact that all the members are men—is that there is no one in the group who is a financial expert. Given that the issue is resources, the management of finances, efficiencies and doing things better, it seems to me that there is a gaping hole in the membership of the group. Perhaps we should take up that issue directly with the Scottish Government.

Given that what the group is addressing is, in essence, a financial challenge, I would have thought that it was a mistake not to have somebody in the group with relevant financial expertise. We should draw that to the attention of the Government and suggest that it rectifies it as soon as possible. I am not talking about having someone who has expertise in the internal financial structure in Tayside; I think that having an external person in the assurance group who has relevant financial expertise and perhaps resource management expertise would be a huge advantage for the work of the group.

Professor Connell: I will comment briefly on that, but I agree. There are two points to make. First, the chief executive of Fife will provide valuable comment on delivery and how that impacts on finance, because a lot of problems relate to delivery rather than to adding up the sums, if you like. However, you are right that having financial modelling expertise would be helpful. We have discussed that with the Scottish Government and I think that its proposal would be that the original group of three might look at where the gaps are and then recommend additional resource as necessary.

Alex Neil: Yes, but I would have hoped that you would have had a financial person from day 1. One of my criticisms of the health service is the lack of enough financial expertise in key areas, and the assurance group is possibly one of those areas. Given that the group is supposed to report within three months, it seems to me that there is no time to lose in filling the gap.

The Convener: Could we take that up with Mr Gray?

Alex Neil: Yes.

The Convener: I can also let you know that the number 9 bus in Dundee has traditionally had a circular route.

Alex Neil: That is appropriate. [*Laughter*.]

The Convener: So it goes round and round in circles.

Liam Kerr (North East Scotland) (Con): The one-year plan says that for 2017-18 the board will fall £4 million short of the £49.8 million savings target. The convener asked earlier about a number of the savings that are categorised as high risk, and I heard Mr Bedford's answer. However, I take it that high risk means that there is a high risk of the savings not being achieved. Does that not mean that there is a fair-to-good chance that even more than £4 million of brokerage—that is, loans—will be required in 2017-18?

Professor Connell: I will pass that on to Mr Bedford, because I think that it comes down to what the term "high risk" means. However, in any budget scenario one would always assign levels of risk to where savings will be made and categorise them as low, medium or high. As Mr Bedford indicated, a high risk means that at present we are still developing the strategy to ensure that we will deliver within the year, but it does not necessarily imply that we think that it is unlikely that we will get there; it is just that the planning assumptions are still being solidified. I ask Mr Bedford to clarify that.

Lindsay Bedford: It is exactly as Professor Connell said. For me, the term "high risk", which we touched on earlier, reflects that we are talking about decisions that need to be taken in partnership. I did not mention earlier that one of the high-risk initiatives is the delivery of the 72-hour delayed discharge target. The chief executive has given you an indication of the number of patients who are currently in hospitals across Tayside. We have to work in partnership with our health and social care partners to improve the patient flow and reduce the level of delayed discharges from hospitals. We are promoting such discussions right now to enable the significant resources that have gone into the health and

social care partnerships over the past two years to liberate resources for the hospital sector. At this stage, as you will have seen from the figures quoted today, there are still a significant number of patients in the hospital sector, both in the acute hospital setting and in beds that are under the control of the IJBs.

Liam Kerr: But is it correct that there is a high risk that you will not deliver £5 million of savings in the next year? That is what the high-risk category means.

10:15

Professor Connell: With any budget, one has to accept that there is a risk. We agreed with the Scottish Government that we would stratify our risk, which is what we have done.

Liam Kerr: Correct, but there is a risk that £5 million of savings will not be achieved. If that is correct, the £4 million of extra brokerage that you will require is lowballing.

Professor Connell: I think that that is one of the reasons why we welcome, and the Scottish Government has recommended, the assurance group coming in at an early stage—

Liam Kerr: But I am correct in my impression.

Professor Connell: Yes.

Liam Kerr: If that is right, we then have a category of medium risk. What are the prospects of achieving medium-risk savings?

Professor Connell: Again, I will pass that to Mr Bedford to clarify.

Lindsay Bedford: If we reflect on previous years' financial plans, there is an expectation that medium risk will migrate in the early part of the year into low risk and will be delivered in full.

Liam Kerr: Okay. For the record, you project that over the next year you will deliver 100 per cent of the medium-risk efficiencies in the table—£12 million.

Lindsay Bedford: There will probably be a bit of a mixture. We will see some of the high risk going into medium and low.

Liam Kerr: Will the savings be delivered?

Lindsay Bedford: That is what we are discussing with the chief officers of the three partnerships and the acute hospitals unit.

Liam Kerr: You talked about previous years. How many of the medium-risk targets were achieved for savings in previous years?

Lindsay Bedford: In the main, medium risk migrates—

Liam Kerr: How many were achieved?

Lindsay Bedford: In terms of—

Liam Kerr: Was 100 per cent of the savings targets that were classified as medium risk achieved?

Lindsay Bedford: I do not have the figures here. I can provide information about the plan at the start of the year and where it ended up at the end of the year.

Liam Kerr: That would be useful.

I come to my final question, although I may come back in later. The Scottish Government told us in February that it expects you to be in financial balance by 2018-19 and to require no further brokerage. Do expect that?

Professor Connell: Yes. That is the basis of our five-year financial plan. Obviously that will depend on one or two factors that, as Mr Neil acknowledged, we cannot predict at present because we do not know absolutely what the level of resource available will be. However, to the best of our knowledge, given the planning assumptions that Lesley McLay mentioned, including 72-hour discharges and moving care into the community, we will be in balance.

Gail Ross (Caithness, Sutherland and Ross) (SNP): Good morning. When Paul Gray came before the committee, I touched on prescribing with him, and I would like to return to that in a bit more depth. I refer to pages 14, 15 and 16 of the one-year plan. Who is on the prescribing management group?

Professor Connell: I will pass that to our medical director.

Andrew Russell: The prescribing management group is co-chaired by a clinician from primary care and a clinician from secondary care. The group has multiprofessional representation and therefore contains pharmacists, AHPs, managers and everyone who is involved in prescribed medicines in Tayside.

Gail Ross: On page 14, under "Strategic Context", it says:

"There may be difficult choices and decisions ahead".

What might those be?

Andrew Russell: With regard specifically to the use of medicines?

Gail Ross: With regard to the context in which that is written in the one-year plan.

Andrew Russell: With regard to the difficult choices around the use of medicines, we need to take cognisance of the fact that some of the opportunities to save money may involve switching patients from a medicine that they are on to a medicine that is equally efficacious but is of a

different brand. The choice to do that can be difficult because it involves a clinical consultation with the patient and a level of change that people may or may not be in a position to support us with. It is very much within the context of some of the changes that we require to make.

Earlier we touched on the importance of having a formulary. With regard to the application of the formulary, what we do not know, but will know over time, is the level of prescribing that falls outwith the new formulary and the level of that prescribing that reflects individuals who have chosen to use medicines that fall outwith it as a first and second choice, rather than after they have gone through the medicines that are in the formulary and found those, for whatever reason, not to be the right medicines for them, so they chose an alternative medicine. Through that work, we will be in a position to try to understand the cohort of patients with whom we will need to have conversations around potentially changing those medicines.

Gail Ross: I understand that every patient's situation is different and you cannot just prescribe the cheapest drugs to everyone, because that would not be appropriate.

In 2013, NHS Tayside did well with its GP compliance with the formulary, but in 2015-16 you had the highest spending on drugs in hospitals. How are you looking at how the hospitals and wards are prescribing against the formulary?

Andrew Russell: There are a couple of things to that. We were thoughtful about the data that the Auditor General submitted. Halfway down the page, it said that adjustments to those data could not be made with regard to a number of things. The most obvious adjustment for Tayside is that the population base that is used is 415,000, but we serve the population of north-east Fife, too, which adds another 50,000 patients into that calculation.

We are a tertiary hospital, and therefore our comparator should always be tertiary boards, because a different range of services is provided through tertiary boards and, by definition, some of the medicines that are used for those are more expensive than medicines that would be used in a non-tertiary board. Taking those comparators into account, we do not believe that we are an outlier. Given all those scenarios, there is complexity within the data once you start to examine it and ask further questions about it. That is the specific situation with regard to the hospital element.

We have done further analysis since the Auditor General submitted those data, and we think that there is additional information—we will happily share it—that suggests that we are not the outlier in the way that is described.

On the areas in which we are an outlier, I want to pick up on Mr Neil's point about the importance of using medicines in the context of a patient's care and the continuity of that patient's care. We use a lot of medicines that are different from the rest of Scotland, for patients who require their blood to be thinned, or anti-coagulation. If you look at the graphs that show the reduction of stroke, the reduction in Tayside is significantly greater than the reduction across the rest of Scotland. There is some expense at the front end that ultimately impacts our ability to scenario plan into the future.

We are seen internationally to lead in the use of medicines for hepatitis C. Again, those medicines have a significant expense at the front end, but should we not treat hepatitis C there will be patients who require liver transplantation at the other end. Our rates of that have been lower historically as a consequence of the use of the medicines.

Gail Ross: As we are touching on individual drugs, what is being done to look at the use of particular drugs in hospitals, for example statins, omeprazole or drugs for diabetes or other long-term conditions?

Andrew Russell: To take you back to my earlier comments, in the analysis that we have been able to get from ISD and others only since December we have just about the lowest cost in Scotland for treating a patient with diabetes. Diabetes is a very good example of where we can look at the cost of a patient who is treated in Tayside. However, because we have more patients with diabetes, we have a far greater expenditure related to the range of medicines around diabetes than is anticipated in the budget that we are given.

Gail Ross: What percentage of your budget goes on preventative spend?

Andrew Russell: I will pass that to Mr Bedford, if I may.

Lindsay Bedford: I cannot quote you a figure this morning.

Gail Ross: Can you get back to the committee on that? If you have a large number of patients with chronic conditions, it would be sensible to look at how we can prevent people from getting those conditions in the first place.

Andrew Russell: I fully support and agree with that. That is where our ambitions are collectively for the integration of health and social care—it should be getting into that type of territory.

Gail Ross: On page 15 of the plan, you set out five challenges and there are quite a lot of subheadings under those challenges. When will

we see the prescribing strategy that you mention on page 14?

Andrew Russell: The prescribing strategy work has already started and will emerge over the summer. As I tried to describe earlier, it begins to talk about the use of medicines in the context of an overall disease rather than simply looking at medicines in isolation. It recognises that, in creating some individual efficiencies in that budget, the totality of the spend and the outcome for patients might be poor.

Gail Ross: Do your prescribers feel supported enough to make those changes? How are you supporting them?

Andrew Russell: The prescribing management group works very closely with our professional advisory structure, through the area medical committee, the GP sub-committee and the consultants sub-committee, all of which are on board on that. We have put significant investment into pharmacy support for practices. Tayside was one of the early adopters of the practice-based pharmacy model. Historically, the focus has very much been on some of the qualitative elements around that. We have already touched on variation. There are areas of variation in prescribing that we very much support and will continue to support as being clinically the right thing to do. The areas where we cannot justify that are the types of areas where we will focus some of the additional support.

Gail Ross: Do you have any projections for the savings that there would be if you had a bigger uptake of the minor ailments scheme?

Andrew Russell: I am sorry, but I do not have those details. I have not been party to the work on that. I do not know whether Mr Bedford has those details. However, we will happily supply them to you.

Gail Ross: Okay. That would be good, because I know that Community Pharmacy Scotland is focusing on that just now. I think that there is a pilot in Inverclyde to try to get more people to use the scheme, and the savings are certainly in the millions, so that might be something that we could look at.

On page 16, the plan sets out efficiency savings. There are two bottom lines, of £6.2 million and £3.8 million. In order to reach those, are there any plans to cease prescribing any items?

Professor Connell: Mr Bedford can comment on the figure of £3.8 million, because that is the simple impact of changes as a result of drugs coming off patent.

Lindsay Bedford: That is correct. In 2017-18, we expect a number of drugs to come off patent. We expect that to provide a benefit of £2.4 million—

Gail Ross: So that is a result of moving from brand-name to generic drugs.

Lindsay Bedford: Yes. The full-year impact going into 2018-19 will be £4.5 million, so that will be a further £2.1 million coming in to benefit the board in 2018-19. That will benefit all boards.

The other element relates to tariff price reductions. That reflects discussions with the contractors on the prices. We expect a benefit of £1.4 million to be delivered in 2017-18. Again, there will be a national benefit from that.

Gail Ross: So there are no plans to stop prescribing anything.

Professor Connell: I will ask the medical director to comment, particularly on lidocaine patches and pregabalin.

Andrew Russell: The lidocaine patches are medicines that are used for controlling very severe pain. Their indication is for very restricted use. Although we now comply with that restricted use, in NHS England and other parts of the NHS in Scotland, their use is extremely limited, but we have a number of patients who are getting it. Lidocaine is a good example of where it is in patients' interests not to have the level of access to a medicine that they have currently.

Gail Ross: At the bottom of page 14, the plan says:

"The Realistic Medicine Workstream is integral to the ... Five-Year Transformation Programme".

Can you tell me a little bit about that?

Professor Connell: The realistic medicine workstream is one of our key workstreams in the transformation programme. It is led by Professor Margaret Smith, the dean of nursing at the University of Dundee. She has wide experience of health service delivery, and was previously the head of nursing at NHS Greater Glasgow and Clyde.

The workstream is designed to look at not only effective prescribing, but the effective use of medications and interventions, including ensuring that patients are offered only what is most appropriate and that they are not overtreated inappropriately.

10:30

Gail Ross: To return to the issue of the bottom line saving, under another line of questioning you mentioned that there was a split between the IJB and what it has to save through the GP practices and what you have to save with other prescribing. Is that £3.8 million saving to be split? Is that

saving solely yours, or does it come in part from the IJB, too?

Lindsay Bedford: The £3.8 million relates entirely to primary care medicines, so the saving is through the GP practices.

Gail Ross: Who from NHS Tayside sits on any of the IJBs?

Professor Connell: The IJBs are chaired either by an NHS Tayside non-executive member or by a nominee from the council. At present, the three IJBs are chaired by members of NHS Tayside board. Two of them are employees of NHS Tayside; one is an employee of Dundee City Council. The IJB board is populated either by nominees from NHS Tayside, who are non-executive members, or nominees from the council, some of whom are elected councillors.

Gail Ross: NHS Tayside has relatively high influence over the IJBs, so—hopefully—you will be able to ensure that they make their savings, too.

Professor Connell: Yes. However, I remind the committee that the IJBs were established as autonomous bodies.

Gail Ross: Indeed. I just hope that, if the total savings are not made, the IJBs will not be used as a scapegoat. However, if you are controlling them, that will not be the case.

The Convener: I will pick up on Gail Ross's point about the IJBs and prescribing. Earlier, we touched on the projected savings being high risk because £1.9 million of them are based on lower prescribing levels. Will it be more difficult to get a grip of GP and primary care prescribing because the GP practices fall under the IJBs?

Andrew Russell: There is less of an issue with GP practices, but there are more issues on governance, which we have touched on. Through the use of formulary and our agreed protocol for the use of medicines that fall off that formulary—and therefore the level of agreements and permissions that are needed in order to do that—we are in a position to be confident that there should be consistency in the standards of the prescribing and the decisions made, irrespective of where the prescriber sits in the organisation. At the end of the day, those decisions are made in the patient's best interest—and we are all individual and medicines impact us in different ways.

The Convener: Do you know how often GP practices review repeat prescriptions? The stockpiling of medicines is an issue in Dundee.

Andrew Russell: Historically, the quality and outcomes framework, which is part of the contractual obligations for general practice, placed a 12-monthly requirement on medication review. We determined compliance through a payment verification model in which we sampled a number of the practices and went in and checked the GP practice's books and some of the patients to ensure that those reviews happened. We have no reason to suspect that that has not been happening historically.

The Convener: Is that 12-month review target still in place?

Andrew Russell: It is still part of the contract, but, as members of the committee will know, the GP contract is out to negotiation. I am probably not best placed to advise you about where that medication responsibility will land in that.

The Convener: How many surgeries are hitting the target?

Andrew Russell: I do not have those specific details, but we have no reason to suspect that surgeries are not hitting the target. However, you are giving us feedback—and you have given me feedback before—that concerns have been expressed directly to you about that.

Liam Kerr: You need to make £210 million-worth of savings over the next five years. We have been assured that there will be no impact on patients or staff—indeed, we were told that quite clearly in our session in December 2016. However, we have discovered this week that the Scottish Government has to advance another £1.5 million in brokerage, specifically to avoid an impact on care from further cost-saving measures. What has changed in three months?

Professor Connell: This goes back to our earlier discussion. The £1.5 million was agreed with Paul Gray following his appearance before the committee. NHS Tayside had to look at alternative scenarios—if we wished to close off our financial year, one of the options might have been to substantially reduce elective surgery. We could have closed mobile theatres, for example, and stepped down activity.

Liam Kerr: And that would have impacted on patient care.

Professor Connell: It would have had an impact on patients. We discussed that with Mr Gray and the board's preference was that we should not impact on patients. Mr Gray therefore agreed that, to avoid that impact, he would provide additional brokerage.

Liam Kerr: Yes. You have had to increase borrowing to avoid an impact on patient care that we have been repeatedly assured will not happen—

Professor Connell: Yes.

Liam Kerr: —regardless of the savings that you have to make. Is that not correct?

Professor Connell: Yes. Again, I think I said earlier that when we appeared in December, our projections were that we should be able to complete the year with the savings that were outlined in our local delivery plan. There were two areas in which we were unable to achieve the savings, notably around prescribing and a higher level of delayed discharges. That meant that we maintained a level of agency nurse spend and had to postpone some elective surgery, particularly in January and February, adding cost to the system, so we did not meet our savings target. We had added cost because of those two elements.

Liam Kerr: I want to look at the direction of travel. To take a smaller example and scale it up, on page 26 of the five-year plan, you talk about shifting the balance of mental healthcare from hospitals to more community-based provision. You also talk on the same page about

"reviewing the ... large property portfolio"

that you have.

As Lesley McLay is aware, I have written a few times regarding the Mulberry unit at Stracathro, which has been temporarily closed as a result of—we learned from Paul Gray in particular—staffing difficulties. To avoid an impact on patient care, the unit has been temporarily closed. However, the implication of reducing the property footprint and shifting the balance of mental healthcare to the community is that that temporary closure is not in fact a temporary closure at all but a permanent one, is it not?

Professor Connell: No. Part of this issue relates to two parallel processes. You are right that we had to close the Mulberry unit on a contingency basis because we could not safely staff three general adult psychiatry units—one in Murray royal, one in Carseview, and the Mulberry unit. I think that we explained to the committee in December—we certainly did subsequently—that we were running major risks because the level of medical staffing meant that we could not have safe rotas at night, so there was risk to patients. Because of that, we made a decision that we could safely staff two units, at least until August.

At present, we do not know what our staffing complement for junior doctors will be after August, so we do not know what the situation will be. Also, probably two years ago, we put in train a review of mental health services. The underlying principle of that review was that Tayside is an outlier in having more emphasis on adult in-patient care and less on community care, which is counter to current practice. There was a strategy that we should seek to move care into the community where possible.

It was clear that Tayside has too many adult in-patient sites in relation to its ability to manage them safely in the long term. We have seen that repeatedly over the past couple of years. Therefore, we have an options appraisal, which is designed to look at how many units we can safely staff and where they should be. That options appraisal has yet to report.

There are two processes going on; if we come down from three to two adult in-patient sites or even from three sites to one site, there will be implications for how we deliver psychiatric care across the whole of Tayside, in terms of community care. We will not spend less on psychiatry as a consequence—we will spend the money in a different way.

Liam Kerr: My problem is with the semantics. I understand what you are saying, Professor Connell, but people have been told that it is a temporary closure, and "temporary" means not permanent. It means that, at some point in the future, that will cease to be the situation.

Professor Connell: If we have an assurance that we have sufficient junior doctors to staff our rota in August, we should try to open the Mulberry unit again. However, we have an options appraisal exercise coming down the track, and I have not seen the outcome. If it recommends that, in the long term, we move from three units to two and if that implies that Mulberry is not an adult in-patient site, we will move into a process of holding a public consultation, making a formal business case to the Scottish Government, and planning to establish two units or one unit in Tayside. That will take some time. I agree that there is a semantic issue, but the reality is that two processes are happening at the same time, and not through the choice of NHS Tayside.

Liam Kerr: Is it possible that Stracathro hospital could be one of the property casualties over the next five years? Could the Brechin infirmary and Montrose sites be lost altogether as a result of the review?

Professor Connell: No. Stracathro is a regional elective surgery and treatment centre. There is also the potential to increase its use for community services. We run a substantial number of out-patient services from Stracathro and there is no intention of moving away from that site.

Liam Kerr: Can we tell anyone watching that those sites will not be closed over the next five years?

Professor Connell: I will not comment at present on Montrose and Brechin, because they are not part of the mental health review—they are community provisions. The Montrose site has out-patient activity and a small number of community beds. There is a need for a community bed base in north-east Angus, but it would be inappropriate

to start strategically planning now for the number of sites or where they should be.

Liam Kerr: Have there been significant changes in the number of beds on wards in general throughout NHS Tayside as a result of your efficiency savings?

Professor Connell: I will pass that question to my chief executive.

Lesley McLay: My initial reaction is that, in terms of efficiency savings, the answer is no. However, there have been changes. One that springs to mind is a ward in the Perth and Kinross locality that was providing in-patient dementia care. With the development of the community dementia model, we had only one patient in that ward. There was a reducing occupancy level because of an increasing new service model, so that ward is closed at the moment because there is no demand for it. That is an example of somewhere where there has been a change.

Mr Kerr referred to Brechin, and I know that he will be aware of the details of medical care provided by the GP practice in Brechin. That was the instigator of the closure of the Brechin facility, although there are still out-patient clinics running from there. Another example in Perth and Kinross is the creation of an integrated facility for health and social care at Dalweem. We had an old Aberfeldy hospital with low bed occupancy and reducing demand, but we have created a new facility where health and social care colleagues will work under the one roof. The new service models are changing the bed base. If our planning assumptions include a reduction in emergency admissions and in the length of stay, we should be looking for a change in the bed base in our acute sector as well.

Liam Kerr: I understand that there is a concept of boarding, which I believe means that patients who should be on one ward are on a different ward. Have the efficiencies that you have been making had any impact on the numbers of patients who are boarding, and what is the projected impact of the efficiencies on the number of patients boarding over the next five years?

Lesley McLay: The boarding that you refer to occurs with acute sector beds. We have a boarding policy that we adhere to, but you are correct that boarding has taken place. One factor that drives that is the increase in expected emergency admissions, particularly in the winter period. Another factor is patients who are delayed in the discharge process, which means that they are in an acute bed or a surgical bed. If we have an emergency admission, we would normally move a patient whose discharge has been delayed, although the clinicians risk assess who it would be more appropriate to move into a different specialty for a short period.

10:45

Liam Kerr: Are you saying that the considerable efficiency savings that you are making have absolutely no impact on the number of patients who are boarding?

Lesley McLay: From where I am sitting, I cannot think of any decision that the board has taken on that. I will pass that over to my medical director.

Andrew Russell: The key determinant of whether an individual is in the right ward for their care is the level of delayed discharge in our system. Let us be absolutely clear about that. Through the predictive modelling that we do, we know that the Perth royal infirmary site can function effectively and deal with the full range of services around medicine and surgery if there are six delayed discharges in the system. If, as has happened over the last period, there are in excess of 20 delayed discharges in the system, some patients will find themselves being cared for in an environment that is different—a ward that is not the right one for them—as a consequence of that. It would not be as a consequence of efficiency savings. I want to be absolutely clear that the key determinant of boarding in our system of care is the level of delayed discharge.

Colin Beattie: I am looking at page 30 of the five-year financial framework. Would I be correct in saying that any financial model that, at the end of five years, is still relying on 40 per cent non-recurring savings to deliver the savings is unsustainable?

Professor Connell: We recognise that that is a very challenging situation to be in. When we met in December, we said that we wanted to move progressively towards 40 per cent non-recurring savings, from the base that we are currently at. It is still higher than most models.

Colin Beattie: The framework says that £67 million of the savings over the five years will be non-recurring. I see elsewhere in your documents that property disposals will provide £12.76 million. Where will the other £50-odd million in non-recurring savings coming from?

Professor Connell: I will pass that to our financial director.

Lindsay Bedford: That mainly reflects the normal in-year flexibility that we have around management of vacancies. We recognise that vacancy management will always be going on. It also reflects the control of the reserves that the board earmarks, recognising the delays in the normal work of the board. The workforce will be

one of the key areas, recognising the normal pattern.

Colin Beattie: That all sounds very nebulous.

Lindsay Bedford: Over the years, the board has had a higher level of non-recurring savings than we would want. There is certainly an ambition to get a higher level of recurring savings. It would be more encouraging if the level of such savings that we deliver in 2017-18 is higher than the 50 per cent that we are indicating, because that would have a significant benefit for future years and would assist the overall delivery of the return of the brokerage.

Colin Beattie: Leaving aside the money for the property, £50-odd million is a huge sum to take from non-recurring savings. I hear what you are saying about delays in filling posts and all the rest of it—although some of the stuff did not really make much sense to be honest—but the fact is that the situation is more than challenging. Even if all this works out by year 5, how long are you going to be able to continue doing that? You are not planning any improvement at all in the final three years—it is still sitting at 40 per cent. That is not sustainable.

Lindsay Bedford: We have made a small step change this year. In 2015-16, we reported a 35 per cent delivery of recurring savings and, this year, we will report a 40 per cent delivery. As part of the financial plan, there is an ambition, which we believe is realistic, to deliver a 50:50 split in 2017-18. We are taking steps forward. It would clearly be beneficial if the step change in 2017-18 was even greater than 50:50, because that would help our position going forward.

Colin Beattie: You cannot run a business like that. It is not sustainable—that is not how it works, or how businesses succeed. You cannot have that level of non-recurring savings.

Lindsay Bedford: Our ambition is to ensure that the level of recurring savings that the board delivers is as great as it can be.

Colin Beattie: Your ambition is fine, but there is nothing in the plan that shows me how you are going to achieve it.

Professor Connell: I ask Lesley McLay to come in.

Lesley McLay: I do not think that any of us would disagree with you, Mr Beattie. We understand the size and scale of the challenge that we face, and we are trying to be realistic. We know that it is important that, when we say that we will do something, we deliver against that.

We recognise that, over the five years, a level of planning and service redesign work is required. We will end up with slight double-running as we test and pilot things. I used the dementia model as an example. Providing community dementia care at home is the right thing to do, along with earlier identification and prevention, and improving the quality of life for people who have the illness. However, while we are developing those community models, we still have our historical in-patient costs and our fixed costs.

Colin Beattie: But those are not related to non-recurring savings.

Lesley McLay: As we go through the service redesigns and as new services are implemented, we will be able to release recurring costs from the system. We are forecasting over five years, and we have talked about the risk—

Colin Beattie: But you are projecting recurring cost savings already. Now you are conflating non-recurring and recurring savings. It seems that you have estimated that you will save so much through non-recurring savings, and you have just lumped the difficult bits in with non-recurring and hoped for the best.

Lesley McLay: The five-year plan will be assessed every single year. The progress that we have made in 2016-17 is part of the five-year projection and the five-year cycle. We will look at our delivery in 2017-18 and reassess our ability to increase savings. We know that it is important. If we are confident, and we believe that we have in place plans that will allow us to increase our recurring efficiency, the board will absolutely take that decision.

At this moment, given the base from which we started, we are endeavouring to ensure that, if we say that we will do something, we deliver against that.

Colin Beattie: This is just a finger in the air as far as the non-recurring savings are concerned.

Convener, is it possible to ask for a breakdown of where the non-recurring savings are going to be achieved?

The Convener: Yes. Can you can provide us with that, Ms McLay?

Lesley McLay: Yes, we will do that.

The Convener: That would be great.

Mr Bedford, am I correct that your financial year ends next week?

Lindsay Bedford: It ends tomorrow.

The Convener: Yes. At that point, you will owe the Scottish Government more than all the other health boards in Scotland combined. Is that right?

Lindsay Bedford: It will be. The board with the position that is nearest to ours will be NHS 24, which is significantly smaller than NHS Tayside.

The Convener: NHS 24 had huge problems with its information technology, and a lot of its debt is due to that.

Lindsay Bedford: Indeed.

The Convener: The projections that you have given us on page 30 of your five-year change programme—which I touched on earlier—indicate that you expect not to repay £2.6 million of the loan from the Scottish Government. Is that correct?

Lindsay Bedford: The forecast shows the draft position over the five-year period, going up only to 2021-22. As has been mentioned a number of times this morning, we are clear about the 2017-18 budget and the implications of the uplifts. Going forward, the position is less clear.

The current plan makes no assessment whatsoever of the Scottish Government moving the board closer to its target share of parity. We are currently £7 million away from the target share. We were £15 million away following the refinement of the national resource allocation committee model, but an £8 million additional investment in 2017-18 moves us to £7 million away. The assessment throughout that whole five-year plan is that the Scottish Government will not be able to take us any closer to that parity figure. If the Scottish Government were able to take us closer to parity, that would give us additional recurring resources year on year, but that is not factored into the plan at all.

The Convener: To clarify that, if the Government were able to give you parity, as you describe it, how much money would that involve?

Lindsay Bedford: It is £7 million per annum—well, £6.8 million per annum.

The Convener: Would that solve the financial problems of NHS Tayside?

Lindsay Bedford: It would support it.

The Convener: As of tomorrow, you still owe the Scottish Government £33.2 million.

Professor Connell: Yes.

Lindsay Bedford: Yes.

Lesley McLay: Yes.

The Convener: But the £7 million per year would solve that.

Professor Connell: I ask our medical director to comment.

The Convener: That assumes that there will be no spiralling costs at all, if my arithmetic is correct.

Andrew Russell: I want to make members aware that the area that we are touching on is complex. From his experience, Mr Neil will understand the complexities of the NRAC formula and the way that the allocation is used. As a clinician, I am not near to that, but I have received representations from the clinical community, who do not understand why NHS Tayside does not have parity with the rest of Scotland. They recognise that, prospectively, the NRAC allocation is determined against the 2013-14 calculations, and they have legitimately asked what NHS Tayside's financial position has been against parity since that 2013-14 position and what have been the consequences of that. The clinical community has made those representations to me as the medical director, but—clearly—I am not the right person to provide an explanation.

The Convener: As well as scrutinising NHS Tayside, the committee wants to do everything that it can to make sure that you get back to financial sustainability without cutting services, so we can take that up with Mr Gray and get clarification on why that parity is not coming.

To go back to the £2.6 million that is unlikely to be repaid, I ask Mr Bedford whether it is likely that NHS Tayside will still be in debt to the Scottish Government at the end of the five-year period. We have talked about the £5 million of high-risk savings and Liam Kerr talked about the £12 million of medium-risk savings. What would you say to the people of Tayside?

Lindsay Bedford: Clearly, the ambition is to repay the outstanding brokerage as quickly as possible but also as safely as possible. The planning assumption at the moment is that a very small amount will be left outstanding at the end of 2021 and, on the assumption that a reasonable level of saving is delivered in year 6, that would repay the entire outstanding balance.

The Convener: What would repay the entire outstanding balance?

Lindsay Bedford: We showed you a five-year plan, but if we extend that, by the time that we get to year 6, the position would be that we had repaid in full.

The Convener: That is after six years.

Lindsay Bedford: After six years, yes.

The Convener: Forgive me for probing you further on this but, on 15 December, Professor Connell talked about

"our plans for the next five years, which include the full repayment of any outstanding brokerage over that period of time."—[*Official Report*, *Public Audit and Post-legislative Scrutiny Committee*, 15 December 2016; c 21.]

That was less than six months ago. Less than six months later you are projecting that the money will not be repaid. I am concerned about services and jobs in NHS Tayside. We have looked at high-risk and medium-risk savings totalling £17 million. In

the four or five months since Professor Connell said that the money would be paid back at the end of five years, we are already hearing that £2.6 million will not be repaid, and £17 million of savings for this year have been identified as being really risky. Given all that, is it credible for you to tell me that the money will be paid back?

11:00

Professor Connell: You are absolutely correct that it was our ambition in December to have a five-year plan that would fully repay the brokerage. Since then, for the reasons that we have discussed, the brokerage has increased by £1.5 million, which gives us an extra challenge over that five-year period.

An understanding of the revenue resource limit that will come down from the Scottish Government in this financial year has also been factored in since December, with no certainty over what will come in future years. Mr Bedford has created a relatively conservative assumption about the level of resource that will be available over the five years—it is probably more conservative than we had anticipated prior to the meeting in December, which was before the Scottish Government's budget allocation. It is against that revised understanding of what we might expect to have financially, and perhaps a revised understanding of the financial pressures in the system, that we predict that the level of brokerage will still be around £2.6 million at the end of five years if the plan is delivered to fruition.

The Convener: The £2.6 million will still be outstanding.

Professor Connell: Yes—if the plan is delivered as I have outlined.

The Convener: Okay.

Professor Connell: As we have agreed, however, none of us can predict at present what the resource limit will be in five years.

Lindsay Bedford: I have some clarification on the point about effective prevention. On page 50 of the one-year financial plan, you will see at the right hand side of the table that part of the outcomes framework resources that we receive from the Scottish Government is an effective prevention bundle. We get approximately £3.3 million for the effective prevention bundle, which includes items such as the sexual health and blood-borne virus framework, child healthy weight, adult healthy weight and smoking cessation.

Liam Kerr: I have a quick final question that I think people want to know the answer to. What will happen if the plan does not work? What will happen if in five years all of the plans—the savings and efficiencies—do not work? What will happen to NHS Tayside, its patients and its staff?

Professor Connell: It would be appropriate to assure the people of Tayside that, whatever happens, NHS Tayside will continue to deliver safe and effective care. Clearly, if the plan does not deliver in the way that is anticipated, the financial management of that delivery will involve on-going and further discussion with the Scottish Government health department. However, the NHS in Scotland has a principle that it will maintain healthcare services.

Liam Kerr: Thank you.

The Convener: I thank all the witnesses for their evidence. We now move into private session.

11:02

Meeting continued in private until 11:23.

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