OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 16 January 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 16 January 2018

CONTENTS

	Col.
INTERESTS	1
CONVENER	2
SCRUTINY OF NHS BOARDS (NHS FORTH VALLEY)	3

HEALTH AND SPORT COMMITTEE
2nd Meeting 2018, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Ash Denham (Edinburgh Eastern) (SNP)

COMMITTEE MEMBERS

*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
Jenny Gilruth (Mid Fife and Glenrothes) (SNP)
*Emma Harper (South Scotland) (SNP)
*Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*David Stewart (Highlands and Islands) (Lab)
*Sandra White (Glasgow Kelvin) (SNP)
Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Cathie Cowan (NHS Forth Valley)
Alex Linkston (NHS Forth Valley)
Andrew Murray (NHS Forth Valley)
Fiona Ramsay (NHS Forth Valley)
Shiona Strachan (Clackmannanshire and Stirling Health and Social Care Partnership)
Angela Wallace (NHS Forth Valley)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 16 January 2018

[The Convener opened the meeting at 10:00]

Interests

The Deputy Convener (Ash Denham): Good morning and welcome to the second meeting in 2018 of the Health and Sport Committee. I invite everyone in the room to switch their mobile phones to silent so as not to interfere with proceedings. We have received apologies from Jenny Gilruth and Brian Whittle.

We have two new members on the committee, so the first item is a declaration of interests, in accordance with section 3 of the code of conduct. I invite Lewis Macdonald and David Stewart to declare any interests that are relevant to the remit of the committee.

David Stewart (Highlands and Islands) (Lab): I draw members' attention to my role as chair of Inverness Caledonian Thistle Trust, the largest shareholder in Inverness Caledonian Thistle Football Club. The role is unpaid.

Lewis Macdonald (North East Scotland) (Lab): I have no relevant interests to declare.

The Deputy Convener: I thank both new members and welcome them to the committee. I hope that you will enjoy it as much as we all do.

Convener

10:01

The Deputy Convener: The second item is to choose a convener. The Parliament has agreed that only members of the Scottish Labour Party are eligible to be nominated as convener of the committee and, that being the case, I invite nominations for the position.

David Stewart: I nominate Lewis Macdonald.

Lewis Macdonald was chosen as convener.

The Deputy Convener: Congratulations to Lewis on his appointment. I will now hand over the chair to him so that he can carry on the meeting.

The Convener (Lewis Macdonald): Thank you very much, colleagues. I look forward to our proceedings in the months ahead.

Scrutiny of NHS Boards (NHS Forth Valley)

10:02

The Convener: The third item is an evidence session with NHS Forth Valley. I welcome: Alex Linkston, chairman of the board; Cathie Cowan, chief executive; Fiona Ramsay, director of finance; Angela Wallace, nurse director; Andrew Murray, medical director; and Shiona Strachan, chief officer of Clackmannanshire and Stirling Health and Social Care Partnership, which works with NHS Forth Valley. I believe that Alex Linkston wishes to make an opening statement.

Alex Linkston (NHS Forth Valley): Thank you, convener, and congratulations on your appointment. Although there are many areas in which the board is performing well, we fully appreciate that there are other areas in which our performance is not what we would like it to be and it needs to be improved. I thought that I should say that up front at the start.

We hope to have the opportunity to highlight some of the work that is under way to address the challenges that we face, as well as to share some of the many examples of good practice in our board to improve the care and experiences of our patients.

It is also important to highlight the advances that have been made in improving the overall health of our local population. Although, like all health boards, we have areas of high deprivation, there have been significant improvements in life expectancy, along with reductions in premature deaths from heart disease and stroke. We regularly report on the overall health of people in our area and we have provided you with those reports.

We also aim to assure members that, as a board, we, along with front-line staff across the organisation and our council partners, have a clear grip on the areas in which we need to improve and are totally focused on making adjustments. In addition, I am confident that we have the right governance and internal and external scrutiny processes in place to monitor and manage our performance. Those include: board seminars, which focus on specific topics and challenges in great detail; service visits; and our main scrutiny committees—the performance and resources committee and the clinical governance committee—which give our non-executives the opportunity to scrutinise and question our performance and action plans.

We also have a clear strategy for the next five years, "Shaping the Future: NHS Forth Valley Healthcare Strategy 2016-2021", which is closely aligned with the national health and social care delivery plan and the strategic plans of our two integration joint boards. The strategy was shaped through extensive consultations with patients, members of the public and staff and is being taken forward in partnership with neighbouring NHS boards, local councils and other key partners to share best practice and identify innovative and practical solutions.

Safety is the board's key priority. Despite the recent winter pressures, our staff have continued to provide high-quality care. That is borne out by the positive and supportive feedback from many of our patients over the past few weeks. I will quote a couple that we received through social media in the past week:

"I would like to thank the staff at the ICU at @NHSForthValley hospital in Larbert, sadly, my father died on Sunday, but the care he received was thoroughly professional and much appreciated.. Thank You."

The second one read:

"Unexpected visit to @NHSForthValley A&E today with daughter who's broken a bone in her hand. Fantastic service; brilliant staff. Makes me so proud to be a #civilservant."

Those are two of the many plaudits that we have had this year.

We welcome the opportunity to update the committee on our work and we hope that we will be able to answer all members' questions. However, if we are not able to provide all the details that you require today, we will seek to provide the information as quickly as possible.

I thank you for the opportunity to make this opening statement. I will make one further point: Cathie Cowan, our chief executive, has been in post only since 3 January, so I ask you to bear that in mind in your questioning. Fiona Ramsay, our director of finance, has been acting chief executive for the past nine months. That gives some context to our group.

The Convener: I am delighted not to be the only newbie on the block—you have 13 days' advantage on me, Cathie. I look forward to hearing from you as well as from your colleagues, who I know will have a good deal to say in answer to our questions.

I noted that the annual review of NHS Forth Valley took place in September last year and was a non-ministerial review. Is that a new development? Is it surprising or has the board become accustomed to reviews in which ministers do not directly take part?

Alex Linkston: I have been chairman for five years now and have had five reviews. Two of them have been ministerial and three have been non-

ministerial. The board is relaxed about either. Obviously, whether it is a ministerial review is a matter for the minister. The two are different. When a review is ministerial, it is controlled by the minister; when it is non-ministerial, we can have more of an interface with our audience. However, both are beneficial and, in both cases, our board is scrutinised.

The Convener: Thank you very much. I ask Ash Denham to follow up on some of the issues that were raised at the annual review and have come up previously.

Ash Denham (Edinburgh Eastern) (SNP): Good morning and thank you all for attending. I would like to get your view on levels of accountability. As Lewis Macdonald explained, an annual review process has recently started taking place and, if necessary, is followed up with a number of action points. In NHS Forth Valley's case, the action points for the past two years have been pretty much the same, which suggests that there is some challenge with moving forward in those areas. How do you view the reviews? Are they considered instrumental in trying to drive performance forward?

Alex Linkston: I will let my colleagues respond on the detail but the answer is that yes, they are. It is important for every public sector organisation to reflect on its performance. The process is part of the performance culture and of holding the board to account, so it is valuable. There are two tricky issues, one of which is staphylococcus aureus bacteraemias—SABs. Andrew Murray will deal with that.

Andrew Murray (NHS Forth Valley): Good morning. I am the medical director of NHS Forth Valley and have been in post for almost a year. This year's annual review was my first one and I found it helpful. There was constructive discussion, at which there was Government presence, and there was an opportunity for people to take notes for compiling our feedback.

The issue that Alex Linkston asked me to deal with is that of healthcare-acquired infections, in particular SABs. We, as a board and a group of senior people in the organisation, see the figures around issues such as SABs and can relate them to those on other types of infection. We are very much aware of where the organisation is on such issues because we see individual reports from different directorates, so we know when there are areas of concern. For example, I was looking at reports yesterday from our four different directorates showing the breakdown of information on SABs. I could see that in November there was no one within our organisation with hospital-acquired SAB. An acute hospital has to have the highest standard of cleanliness, which allows us to influence the figures for SABs, for example.

Under the SABs heading, there are also figures for community-acquired SAB—staph aureus bacteraemia is a type of blood poisoning. Our numbers on SABs have been higher, but we discussed that this week and think that we have now come down to what would be a baseline. It is difficult to eradicate SABs completely, because people can be predisposed to developing such infections. Community-acquired SABs are a difficult issue for us to influence with a direct action plan, because the SABs could come from individuals sustaining trauma in the home environment or could be related to the high-risk group of substance abusers. There are different ways of trying to influence the SABs numbers. Through our alcohol and drug partnership group, we have tried to target people who run the risk of SABs through intravenous drug abuse, for instance.

We are aware of SABs but think that the numbers have improved. We certainly see areas where we have very close control over SABs and feel that we can get to the point of not seeing any SABs at all. However, as I said, it is difficult to eradicate SABs totally, because a lot of treatments in hospital involve putting little bits of plastic into people, which unfortunately predisposes a small group of people to SABs.

It is useful for the review to flag SABs up to me in my first year in the organisation and it is important that the issue is given the right level of scrutiny. It is a key quality indicator for us, which we look at regularly. As I said, I was looking at it yesterday and will look at it again in a few weeks. I can look at the information with four different groups and committees and see the actions that are being taken to resolve any issues.

Angela Wallace (NHS Forth Valley): I wonder whether I might add something to support what the chairman has said about ministerial and NHS board-led reviews. We have had significant patient and public engagement across all our indicators. I support what my colleague Andrew Murray said on infections, which is an issue that we have dealt with at the highest level. We have also had patient and public involvement, even in terms of the clinical environment, with people coming in and working alongside our doctors, nurses, physios and others to ensure that the environment is clean and supporting us in key areas such as hand washing. We have strong governance in that regard and the public see that as a measure of how well the health service is performing for them. Although there are lots of targets that might interest them, they often see that as the touchstone of whether a board really has, as the chairman said, a grip on things.

There have been significant improvements and, as Andrew Murray said in relation to hospital-

acquired staph aureus bacteraemias, we have months in which there are no cases at all. There are still patients in our communities, though, who have healthcare-acquired or community-acquired infections. We treat them with exactly the same vigour as we do those who have staph aureus bacteraemias in a hospital. Whether an incident involves a member of the public who has been using drugs or someone who has pricked their finger when pruning the garden, we look to see whether there is anything that we can learn to ensure that we can prevent such cases across the system. Despite the fact that those examples involve very different sources, the board ensures that the same rigour is applied.

Our patients and our public are really active on that agenda, and they work hard with us on hand washing and clean clinical environments. As Andrew Murray mentioned, our board is one of the only ones in Scotland in relation to which the healthcare environment inspectorate has not mentioned cleaning. That is a touchstone for the public. When they come into our clinical environments, whether in hospital or in the community, they see a clean environment. We engage with them on what matters to them, and we have extremely robust conversations about infection control.

10:15

Ash Denham: The board did not achieve some of its action points for 2015-16. What happens as a result of your failure to do those things? If that were to happen again for another year, how would you proceed?

Alex Linkston: I will stick with SABs, in relation to which we have probably plateaued. The figure was a lot worse a number of years ago—

The Convener: I am sorry to interrupt. The SABs point is important and has been addressed by Andrew Murray and Angela Wallace in some detail. I know that other colleagues will want to follow up on that. However, I think that Ash Denham's question is more of a general question about how you deal with reviews and recommendations, and what happens when you fail to meet the standard that has been set.

Alex Linkston: Those matters are considered carefully by the board—we take such scrutiny very seriously in an effort to understand why we are in a particular position and what actions need to be taken to improve performance.

That scrutiny is done on an on-going basis by the board. None of the action points that emerged from the review was news to us. We were aware of those points and were already working on them—they are well within our sight. We have not had any surprises; all the areas that have been identified are ones that we are actively working on.

Ash Denham: Does the Scottish Government require anything further at that point? It will want you to keep it informed. Does it require any other action to be taken?

Fiona Ramsay (NHS Forth Valley): I have a couple of points to add in relation to scrutiny. Finance is among the areas that are looked at in the annual reviews, not because there have been any particular issues with our performance—we have always achieved our financial targets—but because of the associated risk. That approach is consistent with the approach taken in other board areas.

When it comes to follow-up, the issues might be different from year to year—other examples are waiting times and access issues. An item might also be mentioned in the annual review letter that has been caused by another issue. We consider that as part of our performance. Our access and ops group has weekly meetings and that flows through to our performance and resources committee, which will scrutinise our action plans and the steps that we are taking to address those issues. We will then have follow-up meetings with the access team at the Scottish Government.

Angela Wallace: I will add a tiny point in support of my colleagues. It feels as though the Scottish Government is really close to those areas and wider areas. There are emerging challenges, and the risk profile will change across a range of things. The relationship feels very close. We also have a formal mid-year review. Through professional meetings with the chief nurse or the medical directors, key issues concerning performance in a range of areas are brought up. The same is true of finance. The chief executives meet on a monthly basis, and there is an extremely rigorous process.

As the chairman has described, we take the responsibility, but it feels as though the Scottish Government is closely alongside us in our efforts to improve. Of course we must improve—the chairman said that in his opening remarks. We work hard to learn from other boards across Scotland and anyone who is best in class outwith the Scottish health service. We have done lots of work in that regard in areas such as safety. As well as the scrutiny, there is improvement support from a range of agencies to make sure that we are learning and preventing the same performance issues from arising.

The Convener: Thank you. Emma Harper has more questions about SABs.

Emma Harper (South Scotland) (SNP): I declare an interest: I am a registered nurse and I used to teach nurses how to reduce incidences of

staph aureus bacteraemias—I taught them about line infections, cannula infections and all that.

Community-acquired infection is not about sticking needles in people and so on, but the data does not reflect that and just shows overall SAB rates. Does the data need to be set out differently, to separate community-acquired infection from hospital-acquired infection? Also, what are you doing to learn from other boards, clinical educators, nurse educators and infection control teams? There are folk who are doing better than NHS Forth Valley, although some folk are doing worse.

Angela Wallace: I will kick off, and I am sure that my colleagues will want to comment. Andrew Murray has commented on how closely involved we all are, whether we are clinical or non-clinical.

We know that, at the national level, the target on SABs is being considered, to ensure that it is doing what it needs to do. The target relates to the number of occupied bed days, and each system has a slightly different approach to how beds support patients in an area.

We have always taken infection control very seriously, as my colleagues said. We have local data on whether an infection is hospital acquired, community acquired or healthcare acquired. We have given you some of that data. There is a month-by-month breakdown, which goes to the board and to the front-line team. There is also dedicated time in relation to clinical governance. We are aligned on the issue, from the front line to the NHS board, and we have the detail about when the most recent instance of SAB occurred, whether it happened in hospital and what caused it. We do a root-cause analysis—all our staff have training and development on patient safety, which includes training in techniques such as root-cause analysis—to see how we might prevent such circumstances from arising again.

We know when healthcare or community-acquired infection relates to a drug-using population or has happened in the community for different reasons. We know what the reason is, and we look at the infection from the individual patient perspective. As a board, we have a way to go; we are a wee bit off the piece, compared with other boards. However, we know with real clarity what is happening and we know that there is no cross-infection.

We have ensured that our staff, our patients and our public see infection control as a touchstone for how well the board is performing. Our infection control teams work with our managers and clinical staff, across the breadth of the clinical community. Infection control is not seen as a management target; it is about patient care, so all training and development happens at that level.

Each ward and department makes very visible to patients, public and staff the most recent incidence of infection. In some wards and departments in Forth Valley royal hospital it has been more than a year—recently, in the gynaecology ward, it was nearly three years since there had been a staph aureus bacteraemia.

There is action and support for the front line, and management and clinical leaders, all the way to the board, are fully sighted on the issue. The board is able to see where Infections have occurred and can ask me, Andrew Murray and the director of public health what we are doing about infection control. We report back on the actions. There is a tight line, if you will, from the board to the front line.

Emma Harper: I will not get into too much detail, but the actions are simple things, such as not disconnecting an intravenous line unnecessarily, scrubbing the hub of the bioconnector and ensuring that it dries and so on. I assume that all that goes on down at the coal face.

Angela Wallace: Absolutely, and the actions to do with the bits of plastic, the cannula that is popped into a patient and so on are part of the Scottish patient safety programme, which has been embraced by the whole of Scotland.

If there are failures, we can see them at the granular level—they tend to be failures of documentation rather than practice. We can see failures per ward, per department, per directorate or across the board, and we can drill down and see whether there was a failure to take a step such as you described or a failure of documentation.

If we find anything like that, we go in and support the staff, because it is about continuous improvement. We have had pretty spectacular results. At a recent visit from the Scottish patient safety programme, people were looking for patients with cannula to see whether we had done the bundle that you described correctly, but they could not find such patients, because we never put a device into a patient unless they absolutely need it. Andrew Murray talked about that. Sometimes a small group of patients will need incredibly invasive procedures, and we need to ensure that our staff ensure that there is no unintentional harm.

I think that we have performed really well. That is why it is really disappointing that we have not quite got to the level that other boards have got to. Although we are only a little away, our staff are quite disappointed about that.

The Scottish patient safety programme supports that, but we also visit other boards. We will go to anybody who is doing something different from

what we do and try to learn and put it into our own context. Even in tough times, the board will never not want to address education, training and development. I am sure that the committee will come on to our financial issues, but we are absolutely clear about keeping patients safe and supporting our staff and population health as well as balancing our books. Without balancing our books, we cannot care properly.

The Convener: That is helpful to a point. You have given full answers about hands-on actions at ward level and said a little bit about what you have done to learn from other boards, but I am not sure that I have heard something that tells me that what you are doing this year is different from what you did last year and is more likely to deliver the targets that have been set in the review. Is there an overview of that?

Alex Linkston: We have to be careful with all targets. As Angela Wallace said, the calculation is based on the bed base. We have a relatively small bed base compared with other hospitals, so our divisor is smaller.

Most of the infections are community based. There are three categories of infection, one of which is hospital infections. As chair of the board, I am satisfied that we have cranked up. We occasionally have infection cases, which are fully investigated and from which any lessons are learned. However, they are fairly minimal.

The other two categories are healthcare infections and community infections. Most are community based. In my view, the healthcare category is erroneous. If somebody has had any contact with the health service and they get an infection, it is automatically classified as a healthcare infection, although it can be nothing to do with a healthcare treatment. If the calculation was based on the total population, I think that our comparative figures would be a lot different.

A lot of our problems are with drug users. We are doing a lot of work with them, and we have done a lot of work over the years to reduce those problems. We investigate cases where there is an outbreak and we do what we can, but drug users are a difficult group to deal with, and it is a moving group. Given that it can change, it is difficult to say exactly what we will do, but we still take that group very seriously. However, what we can do is limited.

With the way in which infections are calculated now and what we are doing as a board, it is difficult to see us substantially improving our performance. If the approach was population based, I think that our comparative figure would be a lot stronger than it is when the approach is bed based.

Emma Harper: Will you clarify why drug users are a more difficult group? Is it because they find veins in their groins and places that are not ones where they can decontaminate the skin in the best way, or because they are not doing that decontamination in the first place?

Andrew Murray: That group is very vulnerable. Drug users do not always take all the precautions that other people would take. Diabetics who inject themselves would always prepare the area properly with sterilisation. We did not think that individuals in our IV drug-abusing community would take those steps. There is the reusing of needles, for example. As I said, we try to work with the group through our ADP to try to improve accessibility to clean needles and the ease of disposal of equipment.

We recognise the issue but, because of those vulnerabilities, it is difficult to reach out to the group in a consistent and meaningful way. As the chair of the board said, the group will be different from the group that existed five years ago. There is a constant process to try to engage with it. I am relatively new to NHS Forth Valley, but I think that we work really strongly with our addiction community. We have really good examples of that work through our public health services. We are really trying to ensure that that group is not left as vulnerable and that it gets the support that it needs.

10:30

The Convener: Thank you. We will move on to one of the other areas where action points were highlighted: access targets and standards, particularly for child and adolescent mental health services and psychological therapies.

Alex Cole-Hamilton (Edinburgh Western) (LD): I was struck by your CAMHS compliance reporting. You have gone from being one of the best performing health boards in the country to one of the worst in a matter of months. I understand that that has to do with staffing pressures, but can you explain exactly what has happened? To go from 100 per cent to below 50 per cent in just three months seems like a considerable dive. Is that entirely about staffing problems? Is there light at the end of the tunnel? Please bottom that out for us.

Fiona Ramsay: It has been almost entirely due to staffing issues, and it is different for CAMHS and for psychological therapies. In CAMHS we have had a range of staffing vacancies, which are filled now, and those people will be coming into post over the next couple of months. That came at the same time as we had some specific sickness issues and some maternity leave. Given the size of the service, that caused a difference of about 10

or 12 per cent in staffing levels, and the remaining staff had to pick up on-going cases that were already in those people's caseloads. Staff are coming back. Maternity leave obviously comes to an end, a number of the staff who have been on sick leave are coming back, and the vacancies have been filled. With all those staff members coming into place and nothing else happening, we are probably looking at June before we can get back to where we were. We see it as a temporary blip, but that obviously does not help the patients.

Alex Cole-Hamilton: That is gratifying to hear, but your risk and resilience planning must take account of such things. People go on maternity leave or fall ill all the time, so are you content that your processes and plans were ready for the blip, and how can we learn from that so that it does not occur again?

Fiona Ramsay: There was a spike. We knew that we would always have to face those issues, but we had a number of them all coming together at one time, and we would normally have expected them to be spread over the year or over the system.

We need to work with other boards to see how we can help to be resilient. We try. We speak to other people to see whether we can get some additional capacity in to help cover in such instances. Across a number of issues, not just CAMHS, that is where some of the regional work may help us and give us a little more resilience. Given the size of our system and our staffing levels, that is probably where we could get some help.

Alex Cole-Hamilton: Although the statistics show us what is not happening, such as young people not getting access to services within the 18-week target, they do not show the maximum worst-case scenario that some of those young people will experience, and that is obviously our chief concern. In that respect, what additional resource can you buy in from other health boards? How can we get those young people seen in a reasonable time beyond the wait that they have already had to endure?

Fiona Ramsay: In CAMHS and psychological therapies, the waits are not the longest that you would see across the service. Even though we are not hitting the target, our waits are not lengthy beyond the period that you see in the statistics. We have been working with parents and have set up a CAMHS parents group specifically to see what additional support can be brought in, and also to give wider support to the family network. We heard at our annual review patient session about the impact that CAMHS and living with a child with mental health issues can have on the wider family. The parents group is a strong support and we have had real help from the Scottish health council to set that up.

Getting support from the regional network has to do with resilience, because everybody will be facing some of those issues at any point in time. It may be the case that, when we are at 100 per cent, somebody will come to us and ask for the same thing, so it is broadly a matter of doing some of the capacity planning across those areas.

Alex Cole-Hamilton: Is the delay in treatment experienced across the four tiers of CAMHS provision, or is it particularly focused on certain tiers?

Fiona Ramsay: It is particularly evident in tier 1. One of the areas that we are focused on is what we would call the point between tier 3 and tier 4, which partly involves learning from other systems. We have been focusing on that point so that we can avoid young people having to spend any time in an inpatient facility, or to minimise that time. The delays are in tier 1 and tier 2.

The Convener: It is striking that, as well as the maternity leave and staff issues that you mentioned in response to Alex Cole-Hamilton, there is an issue around an increase in referrals in the period that is under review. Do you anticipate that trend continuing, or is that a spike?

Fiona Ramsay: I would just say that that has not been so great an issue in relation to child and adolescent mental health services. Pretty much, what we have planned for in that area is what we have been seeing. There might be some variability across the system, but the real challenge around increased referral has been in the area of psychological therapies—referrals in that area have really increased dramatically.

We are not hitting the targets. We have seen 13 per cent more new patients, and there has been an increase of 70 per cent in our follow-up treatment programme. We planned for an average of 375 referrals but there have actually been 484. The situation varies across the system. In accordance with learning from other places, we have been trying to put in some support to the primary care setting so that we can find out why there is variability across practices, which is causing some of the increase in referrals. NHS Dumfries and Galloway has piloted some of that work.

Alex Cole-Hamilton: What efforts are the health board and the local authority making to avoid young people needing access to tier 1 support work? Is there an early intervention programme in NHS Forth Valley?

Fiona Ramsay: That is one of the priority areas in relation to children in our health improvement strategy. We have clear links across social care

and education. The health improvement strategy includes some really good examples of work, particularly in the Falkirk area, around the health and wellbeing of secondary school children who are going through various stresses and strains during their teenage years.

There is a lot of joint work with local authorities, and the issue is a clear community planning priority across the area.

Andrew Murray: We are the only health board that is offering free training in mental health first aid—that is what we call it—which anyone can access. There are some active programmes in the schools, and we are closely partnered with Forth Valley College in our work in this area. There is an impressive initiative called Max in the middle, which is, again, about building resilience in younger school children. It includes mental health along with various other aspects and it evaluates very highly. We have a strong programme in that regard.

The Convener: Cancer is another area in which there is an issue around achieving standards. Can you comment on that, particularly with regard to regional arrangements and planning arrangements and how they impact on reaching targets?

Andrew Murray: Achieving the 62-day treatment target is an area of focus for us. As the chairman said earlier, we recognise that that is an area in which we need to improve. We look at all the data on a monthly basis and we compare health board performance so that we can see which health boards have demonstrated better performance.

We are active members of the regional cancer advisory group, which provides a structure for regional teams to come together to compare performance and to agree on and share best practice. There are also clinical leads who meet to agree what best practice is and what the best pathway would therefore be for patients.

We have a new clinical lead for cancer who is now active; over the next two or three months, the clinical lead will go through every cancer pathway and suggest improvements—we are using regional benchmarking to advise on what our improvements should be. In particular, we are examining NHS Lanarkshire's performance to see how it has managed to achieve what it has done and what we can replicate locally. We are already seeing some improvements, particularly in one of the first pathways that we have examined. We have been able to put in a little bit more resource, which will improve the urology pathway for men. We expect that side of the performance to improve.

There are two parts to the overall cancer target breakdown: the 62-day target, which is about regional and tertiary treatments; and the 31-day target, which is often seen as more for the local health board to achieve as slickly as possible. My clinical background is in the management of people with suspected cancer through to their treatment. The key things are the wait and uncertainty when somebody has symptoms, so there is a need to ensure that that part of their journey is as short as possible and they get the answers that they need to allow them to engage with the clinical teams.

We are aware of where we need to improve. Our referrals to cancer pathways have gone up from roughly 1,000 a month to 1,400 a month, so there has been quite a strain on our system. However, as I said, we now have a new clinical lead who will go through all the pathways. My expectation is that, over the next two or three months, we will have a refreshed programme for them that will demonstrate best practice and bring us up to where we want to be.

The Convener: Is it fair to say that there is a wider pattern of increased referrals from primary care into the acute sector in Forth Valley?

Andrew Murray: That depends on the specialty. The increase is not across the board, when we look at our overall figures. The feel is that our general practitioner colleagues know what specialist input can bring and the tests that it can provide. There is an expectation not just from primary care but from the public.

Fiona, do you know the most up-to-date figures?

Fiona Ramsay: It varies across the specialties. Some have been hit with demographic change. In specialties such as ophthalmology and orthopaedics—particularly orthopaedics, in terms of trauma—there have definitely been increases over this year. We do not see that in some other specialties.

Cathie Cowan (NHS Forth Valley): Because of the Government's detect cancer early programme and its efforts to target groups, not only are GPs observant about what they are presented with but the public are now very aware of symptoms and put themselves forward. Therefore, the referral pattern that we are seeing will probably increase. That is about raising awareness and how our diagnostic services rule out cancer or move people through the pathways to treat them. An increase in referrals is really good if we can catch the illnesses early and intervene. We know that if we do that the outcomes for our patients are greatly improved.

Alex Linkston: When we do not hit the 62-day target, we do not miss it by much. It is certainly a small period and it is all related to treatments. As Andrew Murray said, we are examining all our pathways. It is about trying to take a few days off

some of the treatments so that we can get all our cases within the 62 days. It is not a major issue. We have always been driven by ensuring that people get the best treatment and the appropriate tests. The tests that we can carry out have improved greatly over the years through developments in medical science. We do not have a major problem to resolve, but our intention is to try to hit the target and we hope that the work that we are doing will address that.

The Convener: Thank you very much. A number of colleagues want to ask questions about the position on delayed discharge.

10:45

Sandra White (Glasgow Kelvin) (SNP): I am glad that everyone has managed to get in this morning, with the weather being so bad. Mr Linkston, in your opening remarks you mentioned that some areas need improvement, and I note that levels of delayed discharge and unscheduled care have risen quite a bit. Can you give us an explanation for that?

Alex Linkston: I will ask Shiona Strachan to answer that question.

Shiona Strachan (Clackmannanshire and Stirling Health and Social Care Partnership): Delayed discharge is a multifactorial, multidisciplinary and multiservice area. It is fair to say that there is considerable variation in delayed discharge figures across the piece, both in the mainstream of delayed discharges and in what are referred to as code 9s and the more specialist areas of guardianship. Our figures show that we have had some deterioration, but it is not a consistent deterioration. When you look over the past one to two years, you can see general downward trends in most areas.

We have peak periods and we work to anticipate those peak periods, both through winter planning and through day-to-day planning. We are doing a great deal of work. For example, we have done work across Clackmannanshire and Stirling on guardianships, because we have quite a high level of guardianship in our area. We have carried out reviews of all the guardianships, we have taken advice from the Mental Welfare Commission for Scotland, and we have worked with Greater Glasgow and Clyde NHS Board, which has some specialist input, on retraining and refocusing our mental health officers on how to handle guardianships, given that the legislation and practice tend to move a bit. MHOs had been using quite a traditional method rather than using section 13ZA of the Social Work (Scotland) Act 1968, which is to be used in cases where somebody is unable to consent but where there is a clear impetus because of a pre-existing statement of the person's desires and a clear agreement with both clinicians and family about moving to alternative placements. We had not been using those powers as well as we should have been doing, but we are now seeing the number of cases declining and cases being managed tightly.

Allow me to give you some assurance about the work that is being done on a day-to-day basis. We have weekly calls in place that are supported by the chief executive, and that involves all senior members of staff, including most of the panel members who are here today. We review our activity and discuss any issues that have arisen and anything that we need to go in and sort very quickly. That is supported by senior management team steering groups, which meet every single week to review and flag up issues. I check our delayed discharges on a daily basis, and if you talk to any of my staff they will tell you that I am on the phone the minute I see any kind of variation, if I do not like the look of something or if I have a query. We are working hard to keep up with all of that.

We have multidisciplinary daily huddles in place, so social care staff, third-sector providers and clinical staff are on the ground in the hospitals every day reviewing not just who is delayed in discharge but who is coming through the system. We need to do a little more work on that, but we are getting a lot better at understanding which people are likely to be delayed. They tend to be the people who are pretty complex. If you look at the delayed discharge figures, both in Falkirk and in Clackmannanshire and Stirling, you will see that the people who are delayed are those who have a degree of complexity. It is not straightforward. There are family issues, there are sometimes accommodation issues, and there are frequently mental capacity issues or other things that cause the delay, but that is worked on very heavily. We are also working on our frailty pathway, which is one of the areas where the board knows that we can do some improvement work. The improvement support service—ihub—is involved in that.

Both integration authorities have looked at commissioning and we have recommissioned some of the care-at-home services. Some of them are currently under contract, so Stirling's will not be due for renewal until later this year, but in Falkirk we have jointly commissioned a new provider with a focus on discharge to assess, which has made a huge difference to the Falkirk services. In Clackmannanshire and Stirling, we have rebadged our services as a quick step, to make it clear to staff and providers that we expect a quick one-hour or two-hour response, not a one or two-day response, and that has made a huge difference.

We have initiated a home-first approach. When we talk to families, clinicians and others, the focus is on people going home and not remaining in hospital or moving to another hospital or long-term care—unless they absolutely need to do so. Patients will tell you that what most people want is to go home, in a supported way.

Over the past year or year and a half, we have worked much more strongly with providers. We established provider forums, and the multi-agency strategic planning group, which includes patients, carers, service users and so on, monitors our performance on discharges and supports us by providing direct feedback about service user and carer experience. There is a clear feedback loop in the system.

Sandra White: Thank you for that. The committee has heard about people who are waiting for places to be available and for care arrangements and assessments to be completed. Since the integration joint boards were established, there has been some criticism. I am not blaming the IJBs; their establishment just happened to coincide with the increase in delayed discharge and unplanned bed days. You suggest that the situation has improved since the IJB was established. Has the IJB brought benefits?

Shiona Strachan: I should highlight a specific issue that we face just now. We have a number of care home issues, and some delays relate to care home availability. We were quite badly affected by the fire in the Fife care home that is on the border with the Kincardine area. Falkirk and Clackmannanshire and Stirling have a great number of patients in care homes, and the fire had a knock-on effect, because Fife and our areas had to absorb the people who had been displaced.

In addition, a care home closure is being flagged by one of the providers, and we have a moratorium in place in one of the very large care homes. We are working closely with providers and nursing staff from NHS Forth Valley, particularly in the context of the moratorium, to improve services.

That gives you an indication of the improvement that can come from the much more multidisciplinary approach; there is much more of a shared approach to considering what we can do to make the situation better. That includes work with the providers and stakeholders.

Sandra White: That fits in with the evidence that we have heard. I am pleased that you mentioned care homes. There was a tragic event, and there is an issue with long-term sustainability. I presume that you are talking about the closure of Bield Housing & Care homes in your area.

Shiona Strachan: Yes.

Sandra White: The Health and Sport Committee took evidence from Bield a couple of weeks ago. It seems that there will be a pattern of such closures. Will the health board find it more difficult to place people in care homes if that pattern continues?

Shiona Strachan: Bield and other providers have small care homes, with challenging financial positions and staffing issues. We are seeing that the people who are resident in care homes—even when it is just residential care—require high levels of care. Things are not how they were perhaps five or six years ago, when people who were reasonably ambulant could go into a care home. There is probably very little difference now between residential care and nursing care.

We have some very small care homes, and the integration joint board is about to consider how we can use them to best effect. In Clackmannanshire and Stirling we have used them for intermediate care beds, to support rehabilitation and enable people to get back on their feet through a period of convalescence. We have a £35 million investment in the Stirling care village, which will include the current residential and intermediate care facilities across the Stirling area and some of the community hospital facilities.

We also have a market position statement, which we developed with providers. We are currently working through our commissioning strategy and there will be some tendering activity, probably in the next 12 months, on care homes and extra-care housing. We are currently working with the local authority housing providers on extra-care housing, which is particularly pertinent in Clackmannanshire.

Sandra White: I know that I veered off a wee bit, but thank you very much for that.

The Convener: No, that was helpful.

Ivan McKee (Glasgow Provan) (SNP): I thank the witnesses for coming. I am looking for a wee bit more detail on delayed discharges. The papers say that you had about 33,000 bed days and, in your submission, you talk about the number of specific cases, which I think is about 66 at the moment but has been up at 80 or down at 40—that kind of range. To put that in context, how many acute beds are there in the health board area?

Angela Wallace: For acute beds, we have only one site, which is Forth Valley royal hospital. We designed the models around that so that urgent patients and patients who required elective care were able to be seen equally and one would not gazump the other. Therefore, we talk about bed numbers and spaces because we have lots of spaces for 23-hour day surgery, for example. Our bed number varies slightly but it is about 650. We

also work with our health and social care partners and flex our accommodation during winter or any other time of need for communities.

Ivan McKee: So we are talking about 10 per cent of beds—give or take—being tied up in delayed discharges of one type or the other. What kind of average stay are we talking about for those delayed discharges? Are they typically two or three days or two or three months? Where are we in that range? Do you have that data?

Shiona Strachan: For Clackmannanshire and Stirling, the majority of delays tend to be under four weeks. We are performing within our partnership. We are not hitting the targets—I do not want you to think that I am minimising that—but we are working towards that. However, we perform well against comparator authorities. We perform better than other comparator partnerships and better than the Scottish average.

Ivan McKee: So not many patients are there for a long time.

Shiona Strachan: No. Those who tend to be there are highly complex code 9s.

Ivan McKee: Do you know how many of those you have?

Shiona Strachan: Not off the top of my head, but I can certainly provide that information.

Ivan McKee: You are saying that the vast majority are moving.

Shiona Strachan: It is a handful of patients who are there for a long time.

Ivan McKee: That is good in the sense that it says that you have churn. More people are coming in but those people are not staying very long and you are finding a route out for them. It is not as though you have a huge number—60-odd patients—who are stuck for a long time.

Shiona Strachan: Across Forth Valley, we have a low stay rate.

Ivan McKee: That is good.

Shiona Strachan: It is maintained.

Ivan McKee: To move on to the downstream part of the matter, what cost figure do you have for an acute bed night?

Angela Wallace: It is between £800 and £1,000 per night.

Ivan McKee: Okay. How much do you pay for a care home bed?

Shiona Strachan: A care home is £656 just now, I think, under the national care home contract.

Ivan McKee: That is the figure for a week. So we are talking about somewhere around £800 to stay in an acute hospital versus £100 a night to be in a care home.

Shiona Strachan: There are some variations in that. We have some very small care homes that cost more than £1,000 a week.

Ivan McKee: That is for a week, not a day.

Shiona Strachan: Yes. It is not the same.

Ivan McKee: I have got that in context. Health and social care integration was supposed to fix that problem so that the money would flow and you would be able to realise the gains in the acute sector by spending a small fraction of that money in the care home sector. You talked earlier about care home capacity. Is that the main block that stops you moving those 60-odd people out of the acute sector today?

Shiona Strachan: We have a temporary situation in our partnership with a moratorium in place because of care standards. We expect there to be sustained improvements. We are monitoring sustained improvement at the moment and will review the matter again at the end of January.

The care home sector will not take all of the people. There are six people in our partnership who have highly complex needs and require specialist placements. They are on the delayed discharge list because they are clinically ready for discharge but they have special codes because of the level of complexity.

Ivan McKee: Right. Suppose that we waved a magic wand and you had unlimited care home capacity in the area. You are saying that practically all the people who are on the delayed discharge list, apart from a handful, could be moved out of the acute system.

Shiona Strachan: I think that the majority could be moved. However, we need to be careful, because some are waiting for guardianships—

Ivan McKee: That is what I am trying to understand.

Shiona Strachan: —and there is a legal process in that respect.

Ivan McKee: But what you are telling me is that the number is small in the scheme of things.

11:00

Shiona Strachan: No. There is a small number of highly complex cases. In Clackmannanshire and Stirling, the majority that you are seeing with regard to delayed discharge are guardianship situations.

Ivan McKee: Right. Let us go back to the start and try to break that down.

Shiona Strachan: A court process needs to be followed in respect of those cases.

Ivan McKee: I understand all that—I just wanted to understand the breakdown of those 66 patients.

Let us go back to the start. How many of the 66 are complex cases and how many are guardianship or code 9 cases?

Shiona Strachan: In Clackmannanshire, we have five or six very complex cases. It is a very small percentage; for us, the vast bulk is guardianship cases.

Ivan McKee: Right, and you have said that you have moved through the vast majority of those in less than four weeks.

Shiona Strachan: The majority of overall delayed discharges were moved through in less than four weeks, but the grouping that you are seeing here whose discharge has been delayed are those with guardianship or more complex needs.

Ivan McKee: I need to clarify this, because I might not have been clear about what I meant. At the start, we talked about 60-odd people; when I asked about your delayed discharges, what I meant was how long they were staying beyond the point at which they should have moved out.

Shiona Strachan: I apologise if my response has not been clear.

Ivan McKee: Once someone becomes available for discharge and can then be technically described as a delayed discharge, how long are they in the delayed discharge process?

Shiona Strachan: We will use some of the community hospital beds for some of those people in order to free up the acute provision.

Ivan McKee: But they are still technically delayed discharges.

Shiona Strachan: They are still within the NHS system, as they are legally required to be.

Ivan McKee: How long are people stuck in the system?

Shiona Strachan: Guardianship can take up to three months. It all depends on how fast things happen; private guardianships are particularly problematic, and Stirling has quite a high level of private guardianship applications.

Ivan McKee: Let me go back to my previous question, then: if you waved a magic wand and had unlimited care home capacity, how many of those 66 cases could you move out tomorrow and how many would be stuck waiting for guardianship?

Cathie Cowan: The last time that I looked at the figures—which was yesterday—I thought that the split was almost 50:50.

Ivan McKee: So half of them could go if care home capacity was available.

Cathie Cowan: Yes.

Ivan McKee: Therefore, you are facing two problems: streamlining the guardianship process—which is quite an involved legal process, but it could be addressed at a macro level—and addressing care home capacity. Why are there not enough care homes in the system? Is it a cost issue? Are we making a false economy by saying, "We could save £1,000 a day, but we'll not do that, because we are not willing to spend more than £100 a day"?

Cathie Cowan: We need to think about the whole system. I know that you are looking at a particular point in time, but integration is about the whole pathway. If there is early intervention, particularly with older people, it slows the process down. Older people want to be at home, but they also need support and care, and one of the things that we have been challenged on in that respect is the whole notion of isolation. It is fine for these people to be at home, but we have to think about their need for other things to spend their time on. As a partnership, we have started that work by moving our front door in front of our front door, if you like, in the emergency department for those, particularly our older population and our frail and elderly people, who are coming into the system. We are saying to our social work colleagues, who know these people, "Can we bring these people back home with an intensive package of support instead of their coming into hospitals?" We have work to do right across the pathway.

Ivan McKee: How much does that care at home cost?

Cathie Cowan: The cost is relatively less, but I look to colleagues who know the Forth Valley situation to respond. We have a number of providers who come in and take those patients home.

Having looked at the figures as the new person in post, I think that we have been doing an intensive series of four visits. However, people get on their feet very quickly; we put in additional support to provide less support, so to speak, and then that trails off. However, Shiona Strachan will have the figures to hand.

Shiona Strachan: The care at home varies, depending on who is providing it, but the upper level is between £35 and £42 for what tend to be

services that are provided internally by local authorities.

Ivan McKee: And that is £35 to £42 per—

Shiona Strachan: It is per hour.

Ivan McKee: Per hour.

Shiona Strachan: Per hour per one worker. Some of the people who are being discharged require two workers.

Ivan McKee: So, depending on how long people are in for, what might the daily cost be?

Shiona Strachan: To get to a residential or nursing home care level, you would have to provide circa 35 hours a week in someone's own home. That is the rule of thumb that we use.

Ivan McKee: That brings us back to about £1,000 a week, which again is a long way away from the acute costs. If we look at the macro level—in other words, the 33,000 delayed discharge days last year—and we say that the cost is between £800 and £1,000 a day, that gives us a figure of £25 million or £30 million a year. That is the eyes-on-the-prize figure, but clearly there is some kind of logjam, and we are trying to drill down and find out why it is happening.

I do not know whether the issue is not enough people coming into the home care market, because you are scrimping and saving at that end and therefore missing the big prize, but certainly when I talk to care home people, they say, "If we had a slight amount more, we could open up more capacity." Perhaps you are cutting off your nose to spite your face. I do not know whether that is the scenario, but that is what it looks like from the outside. Do you want to comment on that?

Shiona Strachan: We are doing additional work on models of neighbourhood care—a Buurtzorg-type system—and we have introduced a pilot in one of the rural areas, because Stirling has a huge rural hinterland with a very spread-out population. We are not looking at an urbanised area—

Ivan McKee: I understand that. There are lots of solutions to the issue.

Shiona Strachan: There are, and we working our way through them with regard to the front door and through our frailty work and models of care.

Ivan McKee: And all of them come in at a fraction of the cost.

Shiona Strachan: Yes.

Fiona Ramsay: Perhaps I can comment on a couple of issues that have already been highlighted. First, the majority of our delays are sitting not in our acute system but in our community hospital beds, and we want to change the model that we are using there. We would be talking about much lower costs in that respect.

Ivan McKee: What kind of number would we be talking about?

Fiona Ramsay: I am sorry—I cannot remember off the top of my head, but it would be much lower. We are trying to keep the acute system clear in that respect.

The other thing that we have to take into account in freeing up that capacity is the impact of demographic change. The demand means that it is not a straightforward case of freeing up one bit of the system.

Ivan McKee: I know that it is not as simple as that, although I think that, at a macro level, it is as simple as that. I know that a lot of work has to be done, but it is important not to lose focus on the macro level.

The Convener: That was a helpful discussion. I suspect that the wider issues that have been raised are for the Government rather than the health board to answer, but we will no doubt have the opportunity to pursue those questions.

One thing that I am aware of is that the costs that you have indicated for a night in hospital seem to be higher than those indicated by other sources in the Scottish health service, and we might ask you for further information on that when we write to you after the meeting.

Fiona Ramsay: We are a highly cost-effective system, so I am not conscious of our being outwith any normal parameters.

The Convener: I understand that.

Angela Wallace: We will clarify the detail for you.

The Convener: We will come to the question of cost efficiency in just a moment, but I believe that Miles Briggs wants to ask a quick question.

Miles Briggs (Lothian) (Con): Good morning, panel. I want to look at the situation over the past few weeks when pressures have obviously been at their height and ask about the number of planned operations that have been cancelled in your health board. Do you have a figure for that? What was meant to have taken place?

Cathie Cowan: Up to 15 January we have had 19 cancellations, compared with 22 for the same period last year.

Miles Briggs: Thank you—that is useful.

I am going a bit off course here, but I want to come back to an earlier point about the number of drug and alcohol people in your health board area. Did the health board meet the Government's cut to alcohol and drug partnership funding?

Cathie Cowan: As the new person in post, I was really impressed by the board's priority in that respect. It did not make the reduction, because it saw the issue as a priority; after all, all boards determine their own priorities. From memory, I think that we are continuing to put about £5.6 million into the partnership to support people in what is a very robust recovery programme. There are huge lessons for other boards to learn from the work in Forth Valley, which I have been very impressed with. Indeed, the staff newsletter, which I was reading on my way to this meeting, contains stories about people who have previously misused substances setting up cafes and trying to get into worthwhile employment.

I think that this is a really good and powerful news story, but, in short, we have not reduced the funding to the partnership.

Angela Wallace: We are just about to open our fourth recovery cafe, and the people in the three that we already have are encouraging others by giving them support and bringing them back into work and an active community. We are really proud of that work.

Miles Briggs: Do you keep figures on referral times? Do you have any data that you could provide to the committee?

Angela Wallace: I do not have it to hand.

Fiona Ramsay: We meet all the targets for that and have been at 100 per cent for some time.

Miles Briggs: You face some population-wide challenges. One of the things that I find interesting, as a Lothian MSP, is that there are referrals into NHS Lothian for treatment, and your area also lies between Edinburgh and Glasgow, so that you are placed where there could be access to additional capacity in NHS Scotland. How has your experience of that been, especially given the figure around the 62-day wait that you have recorded, which is 64 per cent? Do you find that capacity is not available outwith your health board area and that that is why you are sitting at that level?

Andrew Murray: Could you clarify which pathway you are referring to?

Miles Briggs: Urgent referral for treatment within 62 days.

Andrew Murray: Is it the cancer suspected figure that you are referring to?

Miles Briggs: Yes.

Andrew Murray: The service is structured in such a way that we have specialists within our own complement of teams, but the rarity of some presentations will mean that we need to work with regional and tertiary teams. We have good links primarily to the west; most of our patients are referred to colleagues in the west region. For very specialised areas, because we know that it will get us the best treatment for our patients, we will use pathways that take some patients to the east. That is not because of a lack of our resources; it is just because of the specialised nature of those cases.

Miles Briggs: Your submission states that

"Some of this relates to local capacity issues",

so I wondered what they were.

Andrew Murray: That probably rewinds into some of the earlier discussions about what is within our gift to fix in that referral pathway. That is why we are reviewing all the pathways and all the steps in them. Ultimately, the pathway is from symptoms to somebody being tested to diagnosis, and it is only once we have a diagnosis that we know whether a person needs to be referred outwith the area to a specialised team. Within our service, we can optimise the earlier part of that pathway.

Fiona Ramsay: If I may, I would like to give an additional example. There are benefits and disbenefits, but a benefit of where we sit geographically is that, although we have had challenges around radiology recruitment, we have been working jointly with Lanarkshire to ensure that the breast cancer pathway has continued to be met, because it requires a radiologist and a consultant surgeon to be there at the same time. Lanarkshire has been very supportive in helping us to keep that as a high priority and to keep the pathway running.

Angela Wallace: Given that we are the pretty bit in the middle between Edinburgh and Glasgow, we find that the clinicians have fantastic relationships across regional networks and with individual services, and we always find that if our patients have needs that are causing a delay, or if other board colleagues have their own patients to see, people are incredibly supportive and understanding. We have to work hard to ensure that seeing our own patients does not have an impact on members of the board who have specialist colleagues, but that works well at both clinical and managerial level, and if we have challenges we raise them with the chief executive, who will have a conversation and try to get the best for both sets of patients. That happens on a day-to-day basis at different levels. People are incredibly collegiate and do incredible things to care for our patients. Those are the relationships that we have and we are all building different types of relationships with regional and national planning, as some of our patients will need to be seen on a national basis, as Andrew Murray has described.

The Convener: We now move on to efficiency savings and the financial targets that have been set in the review.

Alison Johnstone (Lothian) (Green): Audit Scotland's latest report on Forth Valley estimates that efficiency savings of £24 million to £25 million are required for the next three years if it is to meet its financial targets, and that £10 million to £12 million of savings are at risk of not being delivered. I believe that your board has indicated that £6 million of savings will have to be met from non-recurrent sources. How do you plan to achieve those targets and what impact do you think those savings might have on services?

11:15

Fiona Ramsay: We have £24 million savings in the current financial year, and you are quite right to say that about £6 million of that will be covered by non-recurrent means. In common with most boards, I think, we are finding it increasingly challenging to make additional savings. We are continuing to pursue all the traditional routes, but the returns are diminishing.

The figure for next year is probably going to be slightly lower than we had originally estimated at around £18 million, and that includes the £6 million that we have carried forward. We always plan to have cover, because it is incredibly important that we continue to have a sustainable financial position. However, in the past couple of years we have, for the first time, hit challenges with recurring savings.

We are continuing to look at where we have variability and at the big-spend areas. In common with other areas, I guess, we have looked at our prescribing efficiency. A few years ago, we made significant improvements to primary care prescribing; we used to have one of the highest costs in that respect, so we looked at other systems and at what we were doing and we are now the third lowest in terms of cost per head. There are still some areas that we can look at there, and there are definitely other areas such as energy savings that we can do something with, but that will not address everything. I think that the implementation of our clinical services review and our healthcare strategy will have a lot to do with how we drive out some of the costs over the next couple of years. Nevertheless, the situation will remain challenging.

Alison Johnstone: I would like to learn a little more about those non-recurring savings. As you have said, last year was the first time that you were unable to meet your target, and that speaks to the demand that exists and the challenges that you face. Given the many challenges that Forth Valley and other health boards are facing, is it possible to achieve these savings? After all, you are delivering demand-led services, and that demand is increasing. Can you become £25 million more efficient without having an impact on the services that you are able to deliver?

Fiona Ramsay: That is partly the challenge for the management team. Delivering financial balance is a statutory requirement, so we are clear that we have to live within the available resources. We are very clear about balancing the need to meet our performance challenges and the need to deliver quality, and we keep a focus on the three strands in that respect. It is about looking at different delivery methods; we are thinking, for example, about what can be delivered in the community. There are certain out-patient services that could be delivered through technology, which would ensure that people did not have to come to hospital and could free up capacity to meet some of the demand.

We are looking at this on a much wider basis, and we are also looking at some of the prevention agenda to try to take some of the pressure off the system. However, that is a longer-term approach; it is not something that will happen immediately. It is also quite difficult. As you have heard, we have maintained certain priorities in the prevention agenda—indeed, we have done the same with the keep well programme—to ensure that it helps to minimise some of the demands on us.

Angela Wallace: There are also protected areas such as health visiting and family nurse partnerships. With the ADP and other measures, we wanted to try to deal with demand and make savings but at the same time be a bit more thoughtful about the board's priorities in future.

Alison Johnstone: What is almost a tension between the prevention agenda and the delivery of the services that are needed on the ground has been discussed by the committee for a couple of years now. Earlier this week, Miles Briggs and I visited an access practice, where there was a clear feeling that many of the people whom we met, who were in their 30s, might not have been in their present situation had greater emphasis been put on, for example, early intervention. Do you think that we are getting that balance right in health?

Cathie Cowan: We are getting better at it. One of the challenges that the national health service faces is short-termism, and we need to think about the long-term strategy. If we are really committed to prevention, how do we intervene? Is it all about starting well, making links with schools and so on? As for having targets, they sometimes have only a single aim, and we have to think in a broader way and have targets that make up a particular picture. What are the outcomes that we are trying to achieve, and what are the links with, say, starting

out well as a child? By taking that approach, we can slow things down or reduce expenditure.

Going back to the original question about savings, we had a very good debate about delayed discharges and what we could reinvest if we did things differently. We have some work to do on how we respond to the demand and reposition the investment.

Angela Wallace: The board works really hard with some of our IJBs to have prevention at the heart of what we do. We have talked quite a lot about governance today and, to take a very simple thing, the board starts with patient experience and safety, we look at our infection control and we always have a health improvement and prevention topic. With everything that we do, the board is trying to do the demand-led activity as well as transforming health and social care integration, as we have described.

We are trying to keep the focus on prevention—the board, particularly the non-executive members, challenges us all the time to do more of that—and we are trying to balance those things, some of which will be very long term, as Alison Johnstone described in her example. We focus on that, but it is about how to do it at scale. I suspect that all boards and those in the wider discussion are struggling with how we make it much bigger than the good work that we are doing well in each board.

Cathie Cowan: To give you an example, the Scottish patient safety programme was launched in about 2008—clinical colleagues will keep me right—and we are now reaping the benefits of that huge improvement programme. We are reducing infection and so on through prevention in our acute sector. There are things that we can do, but sometimes it takes a long time. It is about having that commitment to the long term and that compelling vision that moves us forward in a way that allows us to demonstrate that we are making improvements, as well as adjusting as we go along. We want to be as flexible as possible to make those improvements.

The Convener: The committee shares the aspirations on prevention and long-term thinking. However, there is an immediate challenge in this year to make those savings, and we have heard about some of the challenges facing you in a number of fields. What do you envisage and expect the impact of the savings you require to make in the next few months to be on services?

Cathie Cowan: We have choices to make—every health board has choices about its discretionary spend. We do that by asking what the implication is if we slow something down or do not do it right away. We make those decisions almost every day, but Fiona Ramsay will have in-depth information about the Forth Valley situation that I probably do not have.

Fiona Ramsay: We are trying to minimise the impact on performance. I stress that we are very clear that we have the three strands of performance, quality and finance. We risk-assess all our savings to see not just whether they are deliverable but what the impact on performance is. We put a lot of focus on ensuring that we have engagement with our clinical community on benchmarking and where there might be benefits. It is about looking elsewhere; for example, we are using the RFiD Discovery system at the clinical level—that is not about execs; it is about the clinicians looking at their performance—and I know that Andrew Murray has been leading on our look at the realistic medicine agenda and how that might be able to help. It is not about direct cost savings—there is not a cash-saving target—but over time that gradual change helps to manage demand and performance.

We look at primary care prescribing and where we may be out of line or have variability across the system, so that we can reduce that variability. We also invested in the hospital electronic prescribing and medicines administration system for secondary care prescribing, because the data has been available in primary care but not to the same extent in secondary care. We used a lot of the data in primary care to help to drive change. We should start to see the benefit of the HEPMA system, which is now embedded in our system, so that the clinicians can see clearly what they are spending across their specialty. That can bring benefits, because it is one of our high-spending areas.

Angela Wallace: I can give an example about how we use our current resources. We work hard to make sure that the nursing and midwifery establishments are safe and effective. The cabinet secretary launched the safe staffing legislation in Forth Valley. We may not have the highest nursing numbers in Scotland, for example, but we have safe staffing levels. Our nursing staff on the wards and in the departments can demonstrate how, through the quality of their care for people, they have prevented falls and, as the chief executive has mentioned, prevented infection, matching their nursing skills with direct patient outcomes. The board has been very supportive. It has not cut staff posts. As Fiona Ramsay has said, we have tried to deliver on the services. This is a real example where the board, using evidence-based tools and looking at the care that the nurses are delivering and what matters to patients, can look at where the investment should be. The board has protected and supported a range of things in that area.

Nursing cannot be ring fenced or excluded from financial considerations. However, the board can see what kind of care we are delivering, what it costs and what the consequences are. If we needed to make changes to such a large and important workforce, I could describe to the board the impact that they would have on services. That is an example of how we use resources well.

The Convener: The committee is also interested in issues of governance. David Stewart has a question about that.

David Stewart: Angela Wallace earlier mentioned the issue of governance. I am interested in governance, particularly in your audit committee. As you know, none of the council-appointed members attended any of the audit committee meetings in a year. Why is that?

Alex Linkston: There is one elected member on the audit committee. Since the elections in May, there has been regular attendance by the elected member.

Prior to May, I wrote to all the chief executives, pointing out the responsibilities on councillors appointed to boards and the fact that those should be taken into account when the chief executives make appointments. We have changed the culture on that issue.

David Stewart: I am glad to hear that. Did you specifically address the previous non-attendance at a formal board meeting?

Alex Linkston: I dealt with it. I spoke to the new councillors who were appointed individually. As I said, I wrote to chief executives before the election and before they appointed new elected members to the board about the commitment required. I think that we have addressed the issue.

David Stewart: Is it correct that there is currently only one council representative on the audit committee?

Alex Linkston: That is correct.

David Stewart: Previously, did it affect the level of scrutiny and debate when there was a no-show at the committee?

Alex Linkston: No. We have other non-executive members. The councillor is one of the non-executive members.

David Stewart: Clearly, the council representative is very important. There is an argument, although I am glad that it has now been resolved, about who guards the guards. If those people do not attend, there could be an empty seat and no debate.

Alex Linkston: I can assure the committee that at all our committees the scrutiny is intense. We are well represented. We get good-quality information to do our job of scrutiny, particularly at the policy and resources committee and the clinical governance committee. We have our own scorecards, and the information goes well beyond the statutory performance indicators. We look at what is important to patients and performance. We make sure that we monitor that and get regular reports.

David Stewart: What has been the attendance of other members of the audit committee since the council election?

Alex Linkston: It is good. There is not a problem there.

David Stewart: If there is any failure in terms of attendance or contribution, what systems do you have in place to remedy that?

Alex Linkston: It is the cabinet secretary who appoints members. If a member was not attending, I would speak to that member. If attendance did not improve, I would probably speak to the leader of the council. I say “probably” because I have never had to go down that road.

I wrote to the chief executives, and I spoke to the new members when they were appointed and made it clear what their responsibilities were. Other than the member referred to, we did not have a problem with the contribution of elected members in the previous administration.

David Stewart: And there are elected members on other committees.

Alex Linkston: Yes, elected members are represented on all our scrutiny committees.

David Stewart: It is good to hear that you have taken on board the problem and addressed it. Clearly, having a well-functioning audit committee is vitally important. I am reassured to hear about the action taken.

The Convener: One of the aspects for which the relationship with local government is particularly important is integration and the integration joint boards. There has been some discussion of that today. When were this year’s budgets set for the integration joint boards and when will next year’s budgets be set for them?

11:30

Shiona Strachan: The budget was set on time. It was set in March, for 1 April. We are currently on track to set the final position on 28 March, for 1 April.

The Convener: Thank you. Some of the comments that the committee has heard on integration joint boards in general suggest that at the ward level—the hands-on level, if you like—the different cultures that local government and the

NHS bring together can work well, but sometimes that becomes more difficult further up the chain of command. Are there comments from a joint board perspective or a health board perspective on how that marriage of cultures is working within the boards?

Alex Linkston: As a health board, we are committed to making the integration work. We work well with the local authorities. There are discussions going on between health board chairs and chief executives and the Convention of Scottish Local Authorities to improve relationships at a national level, and we will learn from that exercise.

We are all committed to making it work. We have talked about efficiencies and different ways of working. We have to support more people in the community if we are going to give people a good quality of life and care for them safely. That requires good interactions between the council and health boards and we are totally committed.

We are also totally committed to community planning. We have very good relationships and work closely with the local authorities and there are a lot of good examples of joint working.

I will let Shiona Strachan speak about the work at her level.

Cathie Cowan: May I first make an observation, as someone who is new to NHS Forth Valley? I started on 3 January, but Alex Linkston and my chairman in NHS Orkney had allowed me to attend a number of meetings, and I was very struck by the transparency and the challenging conservations, because challenge between the organisations is a really good thing in making improvements. At my last Falkirk integration joint board meeting, a number of key actions were really promising.

In the Forth Valley landscape, there has been a track record of integration, both at community planning level and with council colleagues. The care village is an outstanding example of people investing—because we cannot just talk about integration; it needs to be played out in action. As someone new coming in, that is my observation. I am not worried about integration. I think that we can take huge steps forward to make the changes that we know need to be made around the care pathway to support people in their own homes.

Shiona Strachan: Our partnership in Clackmannanshire and Stirling is unusual because it has two local authorities, so we probably have to work a little harder than some areas to ensure that we take account of the variable cultures and priorities, which sometimes push and pull.

As Cathie Cowan said, there is robust discussion. Our IJB is chaired by the leader of Stirling Council, who is extremely committed to the board and to integration. That is a good signal—and it is not true of all integration joint boards. The leader's presence and our robust discussions signal our commitment. It is a challenging atmosphere to work in, but if we can keep the dialogue going—we have managed to do that when setting the budgets and having pretty challenging discussions about priorities and the stresses and strains in the system—there is nearly always a pragmatic view on finding a way through. I meet the chief executives regularly to keep that dialogue going and ensure that we have a single, rounded view on the direction of travel.

Andrew Murray: The connection to the wards is a very important area. Yesterday the cabinet secretary visited NHS Forth Valley, and in the discussion with the clinical team I asked, "As an emergency department team, what have you seen that is a direct result of integration, if you have seen anything?" Staff were able to talk about a team that helps people to get home if we do not think that they need to be admitted. That was a direct result of the communication around integration. For me, it was interesting to see how we are—very visibly—working differently.

Angela Wallace: When Andrew Murray and I met the cabinet secretary yesterday, we listened to staff tell us how well they have been dealing with flu and other things. It was amazing to hear an ED consultant say that if they had more money to spend they would spend it on keeping people safe in their communities. My colleagues in the zone of caring for patients are incredible, but there is a wider aspect, and the ED consultant said that we need to shift the balance and prevent people from going to the ED unless they absolutely need to do so. I am not sure that I would have heard such heartfelt and powerful words even two years ago.

The Convener: How do you, as boards or IJBs, hear from the public that you serve?

Shiona Strachan: The IJB has an engagement strategy and regular engagement. The public forums are still in place and there is regular contact through the community planning partnership networks. In addition, the strategic planning group cuts across all stakeholders, including service users and carers, and there is feedback there. There is also individual feedback through our service feedback loops.

Angela Wallace: Patients and the public are active in our patient public panel, as part of our in-patient services. They bring experience to the IJBs from across the NHS Forth Valley area and give voice to what matters to people when they are receiving services. We have tried to integrate our active engagement. There is active patient and public involvement, from mental health to ensuring

that people wash their hands. Service users are all linked to that process.

The Convener: Thank you. My final question is about accident and emergency performance over Christmas and new year. You will know that the latest figures indicate that over that period Forth Valley had the poorest performance against the four-hour standard. What can you tell us about that? How do you intend to address the issue?

Cathie Cowan: As a new member of staff, I spent my first day at Forth Valley meeting staff in the emergency department. My background is nursing and I was struck by the calmness and organisation in how we were looking after patients. Forth Valley had bought extra beds so that people did not have to wait on trolleys. That is a huge example of the level of commitment to a good patient experience.

The other thing that I was struck by was the near-patient testing. It made me think about targets, in the sense that Forth Valley was putting care and treatment first and targets second. While targets are extremely important, I have a clinical background and I saw at first hand the whole team, from clinicians to social workers, working hand in glove to ensure a good patient experience for people who needed care urgently. I made a point of writing to patients who had to wait a bit longer, whose cases were less urgent, if I can put it like that—everyone always feels that they are an urgent case. For patients coming in who really needed attention there and then, care was our priority. That was great to see.

Andrew Murray: I will expand on what Cathie Cowan said about near-patient testing. It is important to remember the context of the figures. Although it is a four-hour emergency access standard, lots of things happen within those four hours. It is four hours to complete that episode of care, so people are being seen, getting tests and being treated, and decisions are being made about where they should go thereafter.

We looked at the figures at the beginning of December—when I say "looked at", this was not a look back, because we were monitoring actively; a lot of us are very involved in day-to-day monitoring of how we are getting on, what our ED looks like and what our assessment areas are like. You are right, convener. When we saw what was starting to unfold, we were gravely concerned. It is exactly as Cathie Cowan said: we understand that there is an impact on a patient's experience, which is compromised. We needed to find out rapidly what was happening. We saw an evolving picture throughout December and there were some particularly distressing figures.

Flu is everywhere and everyone is reporting huge increases in numbers. I have worked in winter planning for the past few years and we plan for flu every year, but this is the first time that we have seen anything like these numbers of people coming into hospital. People who are otherwise healthy are not usually admitted to hospital; when people are admitted to hospital with a flu diagnosis they usually have other comorbidities—a complex of illnesses, of which flu is a part. As a direct result of that, we have seen the length of stay for people in respiratory specialties go from four days last December up to 14 days this December—there is a huge impact on that group of complex patients.

That is one part, but the other is Cathie Cowan's point about near-patient testing, which means that someone can get a diagnosis of flu within half an hour of turning up at hospital. That is a brand new development this year. In previous years, a diagnostic test had to be sent to an external laboratory and the results did not come back for a couple of days. That is important, because the patient and their family know that the person has flu and, most important, the staff can implement our infection control policies to minimise the spread of that flu.

That is not something that we have done before. Now we know whether someone has flu A, flu B or respiratory syncytial virus and we can look across our bed capacity and, applying the algorithms, see whether a person cannot go to one place and must go elsewhere, which is a process that can have an inherent delay. Once we saw the situation start to unfold, we realised that our policies needed to be more flexible. Cathie Cowan has been in post only for a short time, but she quickly asked us to look again to see whether we could improve our decision making, which we think that we have done. It has been a very difficult month for us and for patients.

Subsequently, performance has improved: it went from the high 50s to 60 per cent in the following week and is now up to 80 per cent. Last weekend, our performance was above 95 per cent. We have improved much of the system. Many other things have happened over the weekend, which has been helpful, but we have learned and improved.

The Convener: Will that change any aspects of your winter planning?

Andrew Murray: Absolutely. We will carry out a debrief as we always do with winter planning. We have had to adapt to the situation as we have gone along. We have got the process in place, but I can reassure you that we are continually monitoring where things are working well or not so well. We will carry out a formal debrief on winter planning and that will be a key feature of what we decide to do next year.

Angela Wallace: Cathie Cowan and Andrew Murray mentioned near-patient testing. I was at the hospital on boxing day when the flu numbers were spiking. We knew what type of flu the patients had and people were very understanding of the delay, although we were trying to minimise it. Our staff were very calm and supportive. We have not had patients being assessed and lying on trolleys. We were getting people out of A and E into a safe ward so that we did not mix patients with flu A and flu B, because, as we know, patients can get three types of flu if they are already unwell or quite vulnerable, as Andrew Murray described. The process started slowly, but we began to re-establish flow and got much quicker.

The patients and their families were kept informed and they understood about the testing. The test is a gargle wash. People were participating in that and they understood that we were popping masks on them in the assessment areas so that we could prevent the spread of flu of any type to other patients.

I mentioned our partners who carry out cleaning in our facilities. That gives people confidence in the health board and in their environment. On Christmas day, boxing day and all the days between Christmas and new year, including the holidays, the cleaning staff were following the nurses and doctors and continually cleaning places so that we could free up spaces for patients.

We appreciate that we need to do better, but our staff were working in really difficult circumstances. As Cathie Cowan said, ambulances were coming up and patients were being brought into the department where we were looking after them—they were not in corridors or on trolleys. Those who waited a long time had full nursing and medical care during that time. I want to reassure the committee on that.

I would not want to do a disservice to our staff, who were absolutely incredible. That was why the cabinet secretary came out and thanked them, which is something that they really appreciated. We thanked them, too, but the cabinet secretary's thanks probably meant a bit more.

11:45

Cathie Cowan: Looking forward, we have one target of 95 per cent but we need to reflect on the patients coming through and consider whether there is an opportunity for Forth Valley to think about reducing that standard for patients who present with minor injuries and being very clear at the outset about redirection and so on. As chief executive—my clinical director will share my view—I want to ensure that we have a very safe system. I would like some measurement around that safe system and whether we are caring for patients appropriately. We want to reflect on that as a health board.

Angela Wallace: Yes.

Cathie Cowan: That will help us to decide where we invest in future. We might invest in the out-of-hours service, for example. There will be huge amounts of data to enable us to prioritise in future.

The Convener: I presume that you can do that without waiting for central Government.

Cathie Cowan: Definitely. We have started down that route and we have learned from that intervention.

Emma Harper: It is not too late to get the flu vaccine and NHS staff and social care staff should get it. Are you doing anything to encourage staff to continue to take up the vaccine?

Alex Linkston: Yes. We are continuing to push the flu vaccination.

Emma Harper: Are you monitoring the percentage of staff who have taken it up?

Cathie Cowan: Yes. On 4 Jan about 40 per cent of our staff had been vaccinated. People are now stepping forward because we have been raising awareness in the public domain.

In Forth Valley we have asked patients attending hospital whether they want to take up the opportunity to have the flu vaccine: we are offering it to out-patients, at-risk groups and so on. We are targeting patients who come into our services. GPs are also doing that, but given that we have an audience of patients, we are promoting vaccination. We have ratcheted that up and we hope that that will increase our figures further.

The Convener: Thank you. That has been comprehensive and you have given us many answers. After the committee has had some discussion we might have further questions. If so, we will write to you with them in the next few days.

11:47

Meeting continued in private until 12:23.

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

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

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

The Scottish Parliament
Pàrlamaid na h-Alba