OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 24 April 2018

The Scottish Parliament
Pàrlamaid na h-Alba

Session 5

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HEALTH AND SPORT COMMITTEE
13th 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)
*Kate Forbes (Skye, Lochaber and Badenoch) (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:

Jacquie Campbell (NHS Lothian)
Jim Crombie (NHS Lothian)
Susan Goldsmith (NHS Lothian)
Brian Houston (NHS Lothian)
Alex McMahon (NHS Lothian)
David Small (NHS Lothian)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 24 April 2018

[The Convener opened the meeting at 10:03]

Interests

The Convener (Lewis Macdonald): Welcome to the 13th meeting of the Health and Sport Committee in 2018. We have received apologies from Alex Cole-Hamilton and Sandra White. Can everyone please ensure that mobile phones are in silent mode? Electronic devices can be used for other purposes, but please do not use them for recording or photography.

The first item on our agenda is a declaration of interests. I formally welcome Kate Forbes, as our most recent recruit, to her first meeting. I also record my thanks to Jenny Gilruth for her service on the committee. In accordance with section 3 of the "Code of Conduct for Members of the Scottish Parliament", I invite Kate Forbes to declare any interests that are relevant to the remit of the committee.

Kate Forbes (Skye, Lochaber and Badenoch) (SNP): Thank you, convener. I have no relevant interests.

Subordinate Legislation

National Health Service (General Medical Services Contracts and Primary Medical Services Section 17C Agreements) (Scotland) Amendment Regulations 2018 (SSI 2018/94)

10:04

The Convener: The main item of business today will be scrutiny of NHS Lothian, but before that, there is an item on subordinate legislation to be dealt with. We have one instrument before us. No motion to annul the instrument has been lodged, but the Delegated Powers and Law Reform Committee agreed to draw the attention of Parliament to the instrument on the ground of a breach of the 28-day rule, which requires that instruments be laid 28 days before they come into force.

The regulations are intended to make corrections that will rectify errors in two instruments that the committee considered previously, and it is for that reason that the 28-day rule has been breached. The view of the Delegated Powers and Law Reform Committee is, therefore, that the failure to comply with the rule is acceptable in this instance. Members have no comments to make, so does the committee agree to make no recommendation on the instrument?

Members *indicated agreement.*

Scrutiny of NHS Boards (NHS Lothian)

10:05

The Convener: We move on to scrutiny of NHS Lothian. I welcome Brian Houston, who is the chairman of the NHS Lothian's board; Jim Crombie, who is the deputy chief executive; Alex McMahon, who is the nurse director; Jacquie Campbell, who is the chief officer for acute services; Susan Goldsmith, who is the director of finance; and David Small, who is the chief officer of the East Lothian integration joint board. I understand that Mr Houston wishes to make an opening statement.

Brian Houston (NHS Lothian): We thank the committee very much for allowing us this opportunity. I will make one minor correction. You introduced Jim Crombie as the deputy chief executive, but I want to make it clear that he is also currently acting chief executive. Many of you will know that Tim Davison is, unfortunately, on extended medical leave at the moment.

I will not rehearse the long list of descriptive material that members have in the briefing pack. I will, by way of scene setting, touch briefly on a number of what we think are the major challenges, which are probably self-evident to everybody, by now. They dominate and influence the work of our board and the day-to-day operations of the chief executive and his team, and are the obvious challenges: the population-growth trends that we face and the demographic changes within that, particularly the ageing population; the rise in demand for acute services that those entail; and the increasing incidence of multiple health conditions—multimorbidity—which impacts on the complexity of the care that we are required to provide. All that is, of course, set against the need to achieve financial balance.

In the briefing pack, we also list a number of areas where we have made progress. I will not reiterate them all, but they include the actions that we are taking against the outcome of the previous annual review. In particular—and for the first time, of course—there is information about the recently introduced regional health and social care planning process, and how we are engaging with that.

Significantly, given the challenges that we face in primary care, the briefing includes examples of what we are trying, testing and developing in terms of new models of primary care and primary care access. The briefing also contains examples of hardware and capital projects, and says where we are with commitments on those.

The following comments will contextualise what I hope we are going to talk about today. From a governance point of view—the board's point of view—it is important to give a flavour of how non-executive board members in particular see NHS Lothian's current development and progress. I will summarise that by saying that we are increasingly moving into an era of risk management. In the challenges that I have mentioned, we are facing what Tim Davison, if he were here, would call "the great conundrum". That great conundrum is how we balance performance management—in terms of protection and sustainability of standards and quality of patient care, and optimising access to services, for example—with the need to achieve financial balance.

We must also balance performance management with the need to support the shift in care from acute services to community settings, and the resource and funding transfers from acute to community services that that implies. The conundrum is in balancing all those factors.

We must also extend that into our requirement, and our stated strategic objective, to move up the supply chain, if you like—to pull ourselves back from treatment into the prevention and inequalities agendas, which we all recognise are the keys to sustainable long-term transformation of how we provide services.

Because of that conundrum and the requirement to balance the issues, the board finds itself increasingly wrestling with how we manage our risk profile. What levels of performance are we prepared to accept in terms of capacity and access targets in order to protect a reasonable financial balance? My board would agree—in terms of the levels of assurance that we have sought—that how the executive is striking that balance and optimising competing, and in some cases conflicting, factors is good, to date. It is adequate; it is satisfactory. We are happy that all the necessary stones are being turned over in order to optimise that balance.

We also wrestle and struggle with a judgmental requirement. If, for example, our outpatient waiting list were—despite all the measures that we are taking to minimise risk by prioritising patients, and to increase access—to go up from 5,000 to 20,000 over an extended period, at what level would the quantum of the total waiting list become a risk that we would have to take different actions about? In other words, when would that perhaps put at more risk our efforts to achieve financial balance?

I have described briefly the—to use Tim Davison's word—conundrum because, increasingly from a governance point of view, those are the issues that we are wrestling with and trying to balance. I hope that that has given the

committee an overview of how we see things and where we are.

In terms of responding to questions, I am happy to field them and to delegate—that is probably the right word—to my executive colleagues, who will have more of the detail. Thank you.

The Convener: Thank you very much. That scene setting is helpful. We will have questions on pretty much all the matters to which you referred.

We heard in another inquiry the other week from a witness who talked about the difficulty of delivering on the preventive and health inequalities agendas because the department that makes a saving might not be the department that then has additional budget to spend. Is that part of the conundrum that you have described? If so, what do you do about it?

Brian Houston: That is part of the conundrum. One of the difficulties, in terms of the accountability of a health board, is that health economics—let us call it that—comes into play. Health economics has, of course, parameters that are wider than simply the accountability of the health board. Therefore, in terms of presenting a business case for something that is directly within our remit, more investment in the prevention and wider inequalities agendas is something that we can, of course, only seek to influence. We cannot directly control it.

Susan Goldsmith (NHS Lothian): One of the things that we are recognising is that we are going to have to take risks. We are increasingly prioritising investment in diabetes and its prevention, for example. That will be a major strategic priority for us. We do not necessarily have a funding source, but the three integration joint boards have committed to putting put money into that.

10:15

In primary care, the board has also taken a risk because we want to support shifting the balance of care. We may not necessarily be able to identify funding up front, so increasingly we take risks. I will reflect what the chairman said. Our focus is this: is the risk worth taking on that investment? We think that it is.

The Convener: What risks are you conscious of?

Susan Goldsmith: The risks are that we do not achieve financial balance and, obviously, that not investing will mean that we will not be able to sustain services. What is so significant is the upward trajectory of demand.

Jim Crombie (NHS Lothian): I will build on what Susan Goldsmith has said. One of the prime examples of a transfer of resource from acute to primary care is the shift of services out of acute hospitals to primary care. The view is that in order to do that we must create the services within primary care and close acute beds, and transfer the funding from acute services transfers over to pay for that. There is a bridging issue, in that case, because we often cannot establish a full service right away; we have to develop the service and, in the interim, we have to maintain the bed base. There is always that challenge. Were the board to decide not to move unless funding was directly available, there would be a status quo and we would not be able to move forward.

The ambition that Susan Goldsmith described is that we are willing to invest in what we think looks like a robust model of care and we will identify funding to maintain the bed base, with a view to transferring resource across once the model is proved to be delivering.

The Convener: Is that partly about the order in which you do things?

Jim Crombie: Exactly.

Miles Briggs (Lothian) (Con): Thank you, and good morning to the panel.

In recent weeks, we have heard concerns about use of an endowment fund by NHS Tayside. Can you reassure the committee that, in NHS Lothian, endowment funds have been spent as would be expected by the donors, and specifically not on medical or surgical care?

Brian Houston: I can, wearing my other hat as chairman of the trustees of the Edinburgh and Lothians Health Foundation, give that assurance, but I will pass that over to Susan Goldsmith to elaborate on why.

Susan Goldsmith: In NHS Lothian, we have a completely separate system of governance of our endowment fund. We refer to our endowment fund as our foundation. We have a separate charter, a separate scheme of delegation, standing financial instructions, all our board members are inducted as trustees as well as board members, and we have clear criteria against which applications for funding are prioritised by the trustees.

The use of such funds for medical equipment is entirely legitimate: the aims of the foundation and of the national health service are the same. Our trustees, however, recognise that we should not be using endowment funding for what we would see as core NHS business. There are clearly occasions when we will decide to invest in medical equipment; certainly, some of the funds that are left to us are specifically for equipment. I am very confident that we have a robust system of governance around our endowment funds.

Miles Briggs: I want to move on to general practitioner services, because one of the issues that has, over the two years since I was elected as an MSP for Lothian, been what can only be described as a crisis within general practice. I do not have time to list the number of pressures within NHS Lothian and the potential closures that we are already seeing. How can that be tackled, and what support should the Scottish Government be providing you with to enable that to happen, given what you have said already about the changing and growing population in Lothian?

Brian Houston: An awful lot that is currently in the planning or early implementation phases is happening, in terms of changes to the whole scheme of general practice, including recruitment and sourcing. I will pass over initially to David Small, who will give more detail.

David Small (NHS Lothian): The agreement that the Scottish Government has reached with the British Medical Association on the new contract is a landmark one. The principle of the GP becoming an expert medical generalist and, over time, moving away from having to manage the whole team and having responsibility for premises is a landmark change. It is important that the BMA and the Scottish Government, health boards and the integration joint boards have agreed in principle on the memorandum of understanding around that. It sets the scene for the next three years of change.

There is a lot of detail in the contract, but there are several key points. The increase in funding for primary care is important; there are two tranches to that. There is the increased income for practices this year, and there is the increased funding to health boards and health and social care partnerships to implement the various stages of the contract.

There are probably two or three highlights to pick out. One is how health and social care partnerships will meet same-day demand in primary care. When you phone your practice and you feel that you need to be seen that day, it is not always possible to get an appointment with a GP. Part of the contract is about setting up new systems to allow people to be seen the same day by a range of professionals—not always a GP, but a GP if necessary. That will allow GPs to focus more on that expert medical generalist role.

The transfer of vaccinations from GP responsibility to health board responsibility is another key component. There will be community treatment arrangements for things such as taking blood or removing stitches. The transfer of responsibility for premises from practices to health boards over time is a long-term programme, as people will no doubt be aware. However, those are key components of the transformation of primary care that we will see over the next few years.

The lead role for health and social care partnerships on developing improvement plans is also really important because that will be done locally with local GP practices and local stakeholders as part of the responsibilities of integration joint boards.

Jim Crombie: We would also be keen to demonstrate some of the work that we have already done. Miles Briggs characterises the situation as being a service that is under duress and I concur with that. Often it is not just about having no money; it is part of our role as a board to ensure that we use the money that we already have in the most efficient way. In our engagement with general practitioners and primary care teams, we have established a number of initiatives to test different models of care.

For example, we are deploying Scottish Ambulance Service paramedics in practices to help with triage and to support the practices. We are identifying mental health practitioners and psychiatric nurses who are being allocated to practices to take away some of the burden. We are pretty advanced in our use of community pharmacy to support GP practices, and we are seeing positive feedback from the practices about the support and relief they get from that.

We are already engaged in work in a number of areas that will form a construct for using this new money and supporting primary care.

Miles Briggs: My question was pointing towards trying to establish what has gone so drastically wrong that we are not able to recruit people to NHS Lothian. I have spoken to many medics who tell me that back in the day, people would be queuing up to come and work in NHS Lothian, including in our GP surgeries. If we look at where we are now, with the number of locums being used and an unsustainable service developing, how have we reached that stage and how do we come back from that, apart from what you are saying about having to rely more and more on multidisciplinary teams?

Jim Crombie: The future is the multidisciplinary primary care team. What has driven that? It is a reduction in individuals wishing or choosing to work in general practice. Equally, younger general practitioners are very clear that there is a work-life balance that they want to establish, and the concept of partnership is not as attractive as it used to be. The workforce ambition—the workforce culture—is changing and it is incumbent on us to recognise that and to support practices to ensure that services to patients, while being provided by a multidisciplinary team, offer the access that David Small spoke about, offer the outcomes, and offer an assurance that people are being cared for properly.

Alex McMahon (NHS Lothian): To build on what Jim Crombie said, it is about having a multidisciplinary approach. We often talk about general practice, and that refers to GPs, but there are many others—pharmacists, paramedics and nurses. We are now training a number of nurses in advanced practice, which means that they will be able to do a lot of the assessment, diagnosis and treatment.

We are going through a process of upskilling our general practice nurses—the ones who work in practices—so that they can do more around long-term conditions and, indeed, we are looking towards district nursing as well. We cannot be dependent on one professional group; we have to look at them all.

Alison Johnstone (Lothian) (Green): I want to understand whether the panel believes that difficulty filling posts and a lack of supply doctors fundamentally begins with a lack of training places. If you are saying that more people are attracted to a better work-life balance and that being a partner is not as attractive as it once was, are the 898 places that I believe were available in 2017 sufficient or do we need to be ramping up that number?

Jim Crombie: There are a number of issues around that. The attrition of trainees is a major issue that we need to look at. In training, we need to make sure that the concept of primary care is attractive to people. The training programmes perhaps need to have more opportunities for trainees to understand what is available in primary care.

However, I seriously believe that we should not focus all of our attention on general practitioners. I think that having a sustainable future is predicated on a multidisciplinary approach, so although we might see an increase in trainees as being the answer, that needs to be balanced against the availability of other practitioners who would offer as good, if not better, a service to the practice population. I believe that this is about a multidisciplinary future.

Alison Johnstone: Okay.

Kate Forbes: NHS Lothian should be in a relatively strong position to recruit and retain staff, in terms of your location—I speak as a rural MSP. However, there are high vacancy rates among a number of medical specialties, particularly urology and dermatology. How do you explain those vacancy rates?

Jim Crombie: I would concur with your comments. NHS Lothian is in a good position in terms of its ability to attract clinicians. You characterise a couple of examples where we are having difficulty. There are a small number of specialties where we are having difficulty attracting individuals.

From a positive point of view, for the vast majority of specialties we continue to maintain a positive recruitment model, apart from in certain areas such as urology. If you look at the situation for urology United Kingdom wide, there are more posts available than there are consultants who are ready to take up those posts. Doctors who have completed their training and are ready for consultant posts now have an opportunity to think of different posts and, although we might assume that NHS Lothian is an attractive proposition, people are choosing district general appointments. People are choosing to return to the areas where they have come from—to their home towns and so on—so it is a complex environment.

Kate Forbes: What are you doing to attract people to these posts—to be more competitive than other places?

Jim Crombie: We have an elegant and detailed understanding of what the demands are. I will continue to use urology as an example, if that is okay. We are identifying technology and innovation that will support the workforce to continue to provide that service.

We currently have just one clinician who has a clinical expertise in prostatectomy. We projected and identified that as a major demand stream, so we looked at the technology that was available to support that individual consultant and we were lucky enough to be chosen to deploy the new urology robot. That has provided an environment that gives a bit of resilience and support to that individual consultant but in terms of attracting new consultants to that area, it is also a perfect example of the type of thing we are doing.

With our other clinicians, we look at job planning, because work-life balance continues to be a theme that we have to evidence opportunity for in our recruitment process. It is a combination of a number of things.

Kate Forbes: You mentioned long-term planning; are you currently looking ahead for potential pressures in other medical specialties? What might they be?

Jim Crombie: In our submission, we talked through our workforce planning. That has become more comprehensive as we have engaged with our regional partners in NHS Fife and NHS Borders. We have identified a number of specialties where we believe there will be pressures. One pressure comes from the current workforce profile—the number of clinicians who are at a point where they are within five years of retirement. We are identifying that as a resilience issue. We are looking at the demand profile at a sub-specialty level around what is coming into the

organisation, and we are looking at the availability of trainees to understand whether there will be consultants available.

It has been a more comprehensive approach in relation to our agenda; we are looking at things such as the elective centres, and we are trying to identify opportunities to deal better with the demand. Jacquie Campbell might talk about our process on that.

10:30

Where we have looked ahead, we see real pressures in some of the specialties. We have talked about urology. There are also issues around radiology and anaesthetics.

Jacquie Campbell (NHS Lothian): Very often it is that real sub-specialty expertise that drives pressures in recruiting. Urology is a classic example; Jim Crombie has explained that at the moment, we have a single operator for robotic prostatectomy.

Although we have not been able to recruit a substantive post there, we have been successful in getting a two-year locum to come in and join that team, which will have a positive impact for urology. We have also just recently been able to recruit a consultant who will focus on some of our cancer pathways in relation to urology. It is very often that sub-specialty area where we may have recruitment difficulties.

Jim Crombie: Part of our response is similar to our response on primary care, which I explained earlier. We are identifying that the solution at a specialty level is not just consultant based. It is an opportunity, as Alex McMahon mentioned, to develop advanced nurse practitioners, to look at the role of allied health professionals, and to look at primary care in a different way in terms of maintaining people. It is a whole-system process to try to ensure our ability to deal with the pressures that we see coming.

Brian Whittle (South Scotland) (Con): I want to explore the fact that in terms of workforce planning, it is not just about recruitment; it is about retention of staff and the increasing pressures in the environment in which they work. Are we cognisant of the health of our healthcare professionals? That speaks to a continuity of care and speaks to absenteeism as well. What are your thoughts on the environment in which our healthcare professionals are currently working, and what are you doing to try to create an environment that allows retention and allows recruitment?

Jim Crombie: The first thing is to understand from the individual's point of view how they are feeling. For example, iMatter is a perfect tool for understanding elements of workforce feedback. Some of that feedback raises issues about the pressure that people are under.

It is incumbent on us not just to seek new investment and new funding but to ensure that we are using the funding we have appropriately. That could involve the development of additional admin and clerical resource to reduce the consultant time that is spent on administration work, allowing consultants time to deal with the clinical work. It could also involve identifying other clinical staff, whether it be advanced nurse practitioners or others—again, to reduce the demand on individual people.

Our occupational health service is a key support to us and where we identify individuals who need it, we can offer them rapid access to occupational health. We are cognisant in our workforce plan of the age of our workforce. We are seeing the same demographic changes in our own workforce as we see in the population as a whole. There is a recognition that we are seeing an ageing workforce. In some of the other issues that we look at—the more acute specialties—we need to ask whether there is an opportunity to take the more experienced—I am trying to think of a politically correct term—older members of our team off things such as being on call to try to reduce the pressure and the strain on individuals. There are a number of opportunities to do that.

Brian Houston: I wonder whether we could just widen that and bring Alex McMahon in on the nursing dimension.

Alex McMahon: To build on what Jim Crombie has said, there are also interventions such as mindfulness, yoga, and exercise that people might dismiss but the feedback we have had from staff is that having a 20 or 30-minute session during their lunch break is a really positive experience for them and gives them a bit of resilience. Resilience is the theme at the moment. How do we make our workforce resilient for the current and future environment?

Alongside the things that Jim Crombie has mentioned, we have also talked about the career progression that people can achieve from band 2, when people come into the profession at a relatively low level, and the opportunities to move right through the bands, through the education and training development that we can offer them. We are looking at people as individuals in a career role but also from a wellbeing perspective.

The other thing that we are doing is around wellbeing itself. How do we provide staff with the opportunity to get nutritious food, not just the carbohydrates—the crisps and the snacks that they get sometimes? It is about getting enough fruit and veg. I know that sounds simplistic, but

when you are working in a pressured environment such as an acute ward, it is about making sure that you get a good diet and that you get fluids into you, because drinking plenty of fluids is important, so constantly reinforcing those messages is about wellbeing as well.

Jacquie Campbell: We actively support flexible working hours to support individuals. That depends on their personal circumstances. To build on Alex McMahon's points about wellbeing, we have healthy working lives awards, and a couple of our sites have gold awards. That is also really important. We actively encourage and support staff to exercise and on the dietary elements that Alex McMahon discussed.

We say "Thank you" to our staff, which is really important. There are team of the month awards, and we recognise what staff do on a day-to-day basis and formally thank them. That all adds to the environment of supportiveness for our staff.

Brian Whittle: You will find that I, of all the people in here, will not dismiss the importance to wellbeing through nutrition and being physically active, and the importance of encouraging that environment for our healthcare professionals. However, from a nursing and midwifery perspective, we know that the health of our healthcare professionals falls below the national average. It was stated in a Convention of Scottish Local Authorities submission that our healthcare professionals are prepared almost to sacrifice their own health to look after that of others. There is a high absenteeism rate in many disciplines in the healthcare profession. If an approach is being introduced in Lothian, are there any figures that will tell us that it is being effective?

Alex McMahon: The answer to the nutrition question is no, at this point. We have started a piece of work that follows on from the work on physical and mental wellbeing on which the chief nursing officer for Scotland has been leading. Research evidence has been published by Edinburgh Napier University in Lothian that tells us for a fact that nurses are more overweight than other healthcare professionals. The issue is how we use that evidence to support those colleagues to get physically fitter and psychologically stronger. That is about access to nutrition and exercise, for example, but it is also about the working patterns that we want to look at. Working 12-hour days has a detrimental effect. People get up to go to work at around 6 o'clock and might not get home until 11.00 pm. After that, they get up again to go to work. They do that for three days and are then are off for four days.

The evidence shows that it takes a couple of days to recover from such shift patterns. I want to look with other colleagues at whether those shift patterns are the right ones and whether we can move to an arrangement that is a bit more flexible, but meets the needs of the ward teams, for example. Having shorter days gives people the chance to go home, cook a proper meal—not just grab a snack—and spend time with their family. We need to pick up and do more on being family friendly.

Emma Harper (South Scotland) (SNP): Good morning, everybody. I have a quick supplementary question about other roles that nurses can have. I am a former theatre nurse, and I worked in California. Jim Crombie has mentioned allied health professionals and Jacquie Campbell has mentioned anaesthetics vacancy issues. When I was in my previous role, we had nurse anaesthetists and physician assistants. Is developing nurses' roles for nurse consultants in respiratory or urology, for example, being considered?

Jim Crombie: I will contextualise the matter a wee bit; Professor McMahon can then say something.

The answer to the question is yes—we are exploring a number of opportunities. We can cite the example of theatre nursing. If we look across the spectrum of nursing vacancies, we can see that that is an area in which we have a recruiting problem. We have identified the role of scrub techs: individuals can be trained up and become part of the scrub team, and can take the first place at the table with a patient and a consultant. We took that model from ideas from the United States, but those posts have been developed down south and in other areas.

We have recruited from our own theatre teams. Those people are care workers who work in the theatre. We started a pilot study and trained four people initially, I think, to see whether the approach would work. Obviously, Emma Harper will know from being a theatre nurse that the scrub nurse, the scrub tech and the consultant have a really important relationship. We were keen to test whether the approach would work, and the response was overwhelmingly positive, so we have rolled that out across our whole area.

There is a national issue with respect to operating department practitioners. I think that Alex McMahon can update us on that.

Alex McMahon: First, if Emma Harper is still on the register, I could give her a job. Please apply later on.

Emma Harper: Okay.

Alex McMahon: Jim Crombie has identified a national issue. Glasgow Caledonian University used to run a training programme—it no longer runs it—for operating department practitioners, who very much support the running of the theatre.

In Lothian, we took the lead to try to reconstitute that programme, and it is currently out to tender. We did that on a national basis rather than a regional basis.

Our use of agencies is high. Critical care in theatre is a small area in which we still depend on nursing agency use. We look at regional bank use so that we can ensure that our nurses work in our areas, and we try to grow them. That sits alongside a training programme.

There are scrub nurses, anaesthetic nurse practitioners, advanced roles and theatre technicians, for example. It is a matter of looking at everything from band 4 right through to band 7 and beyond.

David Small: I would like to add some points about primary care. Jim Crombie mentioned advanced nurse practitioner training in primary care. It is not quite the same as that for nurse consultants, but we have a vision for the future of a strong cohort of nurse practitioners working in primary care, partly as part of the implementation of the new GP contract to create that workforce. We already have examples of their working in care homes in roles that GPs would previously have performed and managing a same-day access service in Musselburgh. Nurse practitioners are the core of that service. We also use them in GP out-of-hours provision because of the difficulties that we have had with recruiting GPs, particularly to work out-of-hours shifts. We have funded an advanced nurse practitioner training programme, which we will double the size of this year. That is a key component of moving forward and enhancing the role of the nurses and sustainability in primary care.

The Convener: Brian Houston is the chair of the board, and it is clear that it is his job to hold his colleagues to account for what has been presented as a series of works in progress. I am keen to understand how you measure success. How do you insist that work that is in progress will produce outcomes? How and when do you measure that?

Brian Houston: Over the past four or five years, the board has put quite a lot of effort into the governance that sits around that. For example, we have completely altered our system of risk analysis and risk management and the seeking of assurance about performance against those risk factors. We have restructured the levels of risk appetite that we are prepared to accept or aspire to in respect of all the various factors in our risk register. We seek to delegate from the board table the scrutiny of the detailed performance against each of those factors to our various governance committees and, of course, also to the IJB and the partnership links now.

We think that we now have a fairly robust and secure system in which all the factors in our risk register—which, of course, reflect our strategic objectives—have been analysed and delegated down to the governance committees. They scrutinise in detail performance against those factors and report back to the board when there are gaps, issues arising or, indeed, decisions to be made about significant new remedial actions to be taken to correct the balance.

In the past four or five years, we have moved quite a long way on the security of the structure of governance around performance and performance improvement. Within the past year, we have appointed a head of governance for Lothian NHS Board, whose job is to keep the model of governance on performance and risk that we now have under permanent scrutiny so that we seek to continuously improve and further the security of the system.

The Convener: Susan Goldsmith talked about the risk being particularly to do with financial balance. What is the corporate approach or non-executive board approach to the balance between that financial risk and the clinical risk, which has also been referred to?

10:45

Brian Houston: I will defer to Susan Goldsmith in a moment. In my earlier remarks I spoke about the risk conundrum, and that is exactly what it is. However, the board has defined and agreed its risk appetite priorities, and the number 1 priority is risks to quality of patient care and patient safety. Number 2 is about financial balance. We try to stick with that order of priority when we consider the work that comes back from our governance committees and assess performance and the actions that need to be taken.

I have to be honest and say that very often we are wrestling with the risk conundrum. We find ourselves in a difficult place when making decisions because some of them—particularly those on the financial side of the conundrum—are relatively scientific. We can look at financial elements, measure them and write down the numbers. When we come to look at the safety and care-quality side of that equation, it can become more difficult.

Given that the quantum of people on our waiting list for out-patient appointments, for example, has dramatically increased, there has to be an element of judgment. Once we have taken all the steps that we think it is reasonable to take to mitigate risk as a result of that waiting-list rise, we still have to make a judgment when we come to a point where the quantum of that number means that we simply have to accept that the level of risk is

unacceptable. That is a difficult judgment to make, but it is right at the top. Let me put it this way: resolving that question takes up the biggest share of the board's mind.

Susan Goldsmith: One thing that we outlined in our submission is that we are trying to take a longer-term approach to the board's financial position. Caroline Gardner appeared at the Parliament's Public Audit and Post-legislative Scrutiny Committee and spoke about the requirement for boards to take a longer-term approach to their financial strategy. We are trying to do that, because only by looking forward and trying to plan for the size of the pressure that we will face over the next three to five years will we be able to shape and manage our response. We have just started that. We spent quite a bit of time ensuring that we have good and robust financial management so that we are not compromising clinical care through not managing the money appropriately.

We are now working on how we support an improvement programme across the board, which might not save cash but might support productivity and mitigate that upward pressure. We recognise, as a board, that the only way that we are going to achieve a longer-term financial strategy is by working with other partners—the regions and the IJBs—on strategic planning.

The chairman is right that it is a continual challenge. The only time that we made an explicit decision was when we were going into 2016-17 and did not have the physical capacity to meet all our access targets. We were contracting from the independent sector and we made a decision that we no longer had the resource to purchase activity from that sector. The rest of the time there is a continual balancing act to ensure that we prioritise clinical services.

Alison Johnstone: The panel has spoken about the need to tackle inequalities and get to grips with upstream approaches and prevention, and I appreciate the honesty that we are hearing about the fact that the board has taken an active decision to achieve financial balance. It might be that you cannot invest resource expressly to meet targets. Has the inability to meet targets led to the fact that NHS Lothian has the poorest accident and emergency performance of all boards in 2018?

Jim Crombie: It is useful to understand the quantum around that issue, because it is a very important question. When we look across Scotland, we see that the south-east of Scotland is pretty unique in terms of its population growth. The projections demonstrate growth in the numbers of kids, adults and the elderly, and that is unique in Scotland. The projected population growth is about double that of the rest of Scotland and it is about four times that of the west of Scotland, so there is a real pressure building in our system.

It is interesting to note that in the past 10 years we have seen demand for out-patient appointments increase by about 45 per cent, and we have seen an increase in A and E attendances of about 35 per cent, so a real pressure from population growth is coming into our process.

Alison Johnstone: I suppose that some of that A and E pressure will be to do with the lack of GPs. A colleague lodged a motion yesterday about the GP crisis in West Lothian, and I think that we will be having a members' business debate on that soon. Undoubtedly, all those factors have an impact on people's—

Jim Crombie: Part of our ambition as a board is to understand data and to understand the elements of demand and pressure at micro level. We are now tracking from individual practices the yield-to-attendance rate at the emergency room, and the yield-to-admission rate from that attendance. We are starting to create a portfolio. We are working with the IJBs and the IJB chiefs to try to understand the dynamic. Does it exist because when someone called primary care to get a GP appointment we were unable to offer access and, therefore, that converted immediately into an A and E attendance? Is it an issue of ease of access and people thinking, "I do not need to call the GP. I can just show up at the hospital and I will be treated."? Is it because we are not identifying early enough in a clinical pathway that a chronic condition is changing and that is resulting in an emergency admission? There are a number of flow issues. Using the data will allow us to explore those issues in a lot more detail than we have before.

Alison Johnstone: Moving away from A and E, one on-going area of great concern is the paediatric situation at St John's hospital—even yesterday I was contacted by constituents who were very concerned about it. How is that being dealt with? If you had all the cash and resources in the world, would you be able to solve that, or is there another problem at its core?

Jim Crombie: I will ask Jacquie Campbell to talk in detail about that. I need to be clear that it is not an issue of cash. It is not a funding issue. In its review of the St John's hospital in-patient service, the board committed itself to maintaining the service, and committed an additional £2 million—which, as Susan Goldsmith characterised, is a risk—to make sure that we could attempt to recruit additional members of staff to support the service. I will ask Jacquie Campbell to talk through the detail of where we are.

Jacquie Campbell: As Jim Crombie described, we have an on-going commitment to maintaining

and delivering a 24/7 service at St John's hospital, so that has not changed at all.

In terms of recruitment, despite the national backdrop of a shortage of paediatricians, we have successfully recruited seven additional consultant paediatricians to NHS Lothian. Currently we have five working in the department. One of the most recent appointments that we made earlier this year does not start with us until August, and one of our recent appointments is on maternity leave, but we have five additional consultants in the service.

Over and above that, we have been training two advanced paediatric nurse practitioners. They should be ready to start to participate in an out-of-hours rota towards the end of this year. We are about to advertise again next month for further advanced paediatric nurse practitioners, both to see whether any trained practitioners are out there and to recruit trainee practitioners, and we have a further course starting in September.

As Jim Crombie said, this is not about money. We have had a proactive and continuing recruitment drive. Despite that, out of the 39 out-of-hours shifts that need to be covered every month, at the moment, based on our substantive staff, we can provide about 21, so we still have a way to go before we will have a sustainable out-of-hours rota.

Alison Johnstone: You are saying that that specific issue is not about cash. With regard to all the other issues that NHS Lothian faces, do you have the financial resources to meet the targets that are being asked of you, or is that impossible with the package that you currently have?

Jim Crombie: I guess that I would say that there is a requirement for the board to demonstrate an effective use of the £1.5 billion that it gets, but we have characterised a gap in our ability and capacity to deliver against the access targets. We have been clear to the board and we have been clear to Government that a significant element of funding is required to allow us to recover.

Part of the request from the Scottish Government was for us to present what it calls an operational plan. It used to be called a local delivery plan. We now have an operational plan for 2018-19, in which we have collated all our intelligence on demand, efficiency, productivity and the maximising of our resources. After doing that, we have still identified a gap and we have identified the quantum of funding that would be required to allow NHS Lothian to return to the March 2017 levels of patients waiting more than 12 weeks.

Jacquie Campbell: One element of that issue is that, even if we had the funding to return to March 2017 levels, we do not have the overarching capacity—either internally or with the external providers—to achieve that. There is often a lead-in time when starting up capacity, which is why, as Susan Goldsmith described, we are keen to look at at least a three-year programme, which would give us an opportunity to look at additional resource while we redesign our services.

The Convener: So what is the gap?

Jim Crombie: We presented a series of options that show incremental improvement in the delivery of key clinical priority services, and they show the return of NHS Lothian to 2017 performance levels.

The Convener: You have not only characterised the existence of a gap, but described the quantum of the gap, so what is the quantum?

Jim Crombie: The quantum of the funding that would be required to return NHS Lothian to March 2017 performance levels is circa £31 million.

The Convener: So that is your assessment of the shortfall in funding that is necessary to deliver the services for which you are responsible.

David Stewart (Highlands and Islands) (Lab): We have touched on how you assess risk; Susan Goldsmith covered that quite substantially. I am interested in how you assess risk, how that feeds into the development of your strategy and how flexible you are in being able to do that. On the very last page of your submission, there is a very interesting triangle; basically, you are saying that achieving transformational change is beyond your own capability, and that to achieve that you need to look at regional and national strategy. Is that a correct analysis of your triangle?

Brian Houston: That is a correct analysis, and I would extend it further. If you look at the submission that has been made by the regional team under Tim Davison's leadership, you will see that it states very clearly that the best efforts of the regional planning team to seek additional efficiency-driven benefits have come to much the same conclusion. It has basically said that, at the moment, we can see a way clear to adding some additional benefit, but that will still take us only to the bottom two sections of the pyramid in the diagram in Susan Goldsmith's financial plan.

Therefore, the regional planning function, in Tim Davison's view, now becomes one that says, "Okay, we will do everything we can to go out and maximise these two bottom chunks of the pyramid, but we are saying now very clearly that, in order to move us up to a 6 to 7 per cent cumulative savings target, we are going to have to come up with some different prisms through which to look at the business model, and we do not have those answers." At the moment this is a grey area—we understand the questions, but we need now to put

in a lot more effort, and of course this is a regional if not a national issue. The other regions are coming up with very similar views about it. There is a task to be taken on, which is about the transformational level of change that sits at the top two sections of the pyramid that Susan Goldsmith and her team have constructed.

11:00

David Stewart: You are the second-largest board in terms of population and you have some characteristics that other boards do not have. I will flag up some of those. Among medium risks you talk of prescribing being a problem. Obviously, all the boards of Scotland will come before this committee and say that that is a problem for them as well. Have diseases such as hepatitis C, with which you have some considerable issues, been one of the factors in why your prescribing has been a problem in taking you beyond budget?

Susan Goldsmith: Absolutely. Again, it is not just Lothian; across Scotland, the proportion of the budget that is spent on drugs, whether through GP prescribing or in the hospital sector, has increased. As a result, we have invested a significant amount of resource—with Scottish Government funding and our own funding—into providing pharmacy support. That has generated significant savings, but those savings just have to be ploughed back into supporting the upward trajectory that I keep referring to. We see benefit from investing in pharmacy support, but we require it to continue to fund the increasing drug spend, which is coming either from the demographic changes or from GP prescribing. One of the things that we are seeing now is short supply, and that affects price. On drugs for things such as hep C we have done well nationally, securing reductions in the price because we have worked together across Scotland, but in GP prescribing we are seeing the impact of the global economy on some of the drugs that we procure, so it is a continual pressure for us.

David Stewart: How flexible is the board when it comes to the strategy? For example, if you see changes in the characteristics of your board area, how quickly can you change your strategy? If I can refer to military strategy without being frivolous, I think that it was a German military strategist who talked about any strategy collapsing with the first contact with the enemy. I am not suggesting that that is the way you would look at it, but clearly it is relatively easy to develop a strategy in an ivory tower. Whether it works in practice is another issue.

Brian Houston: Yes, I think that it is not so much your German friend's analogy; it is more to do with the scale and complexity of the deployment that is required, from the point of agreeing a change to strategy, to getting it into place. We are striving to get better at that process all the time, but we are still a very large and complex organisation. It is not an instant process.

Jim Crombie: We developed a strategy and published our strategy in 2014. Alex McMahon can talk through the detail of that, but it was an attempt to characterise what our vision of the future was. That took account of demand. It took account of demographic changes and it took account of disease profiling.

Alex McMahon: "Our Health, Our Care, Our Future" was the name of the strategy for 2014 to 2024. It described a lot of the discussion that we are currently having, but it also articulated the stakes in the ground, as we called it. The Royal infirmary of Edinburgh and the Western general hospital were sites that we would not be discussing coming off, but the question was how we would develop or redefine some of those sites. That allowed us to go back and look at what other services we had on other sites that did not necessarily have to be there, what sites we could repatriate and where we could maximise the opportunity of sites. That has allowed us to progress with a number of closures—I will use the word "closures", but if you want to talk about "shifting the balance of care", I can say that. For example, as well as the closure of Corstorphine hospital and Murray Park, there is the reduction of the bed base at Liberton, the development of East Lothian community hospital and the work around the Royal Edinburgh reprovision. Those were all characterised in our strategy, so we have been progressing those and enacting them over the past couple of years.

David Stewart: I touched earlier how you need other groups to help. Tell me a little bit more about the help and support that you received from the Scottish Government. When you were developing the strategy, what discussions did you have with the Scottish Government, and are there any wider issues for the committee such as how capital planning and revenue planning are allocated? Are there any issues there that we should understand?

Alex McMahon: I will pick up the general point about strategy. It is fair to say that, when we were developing the strategy, our Scottish Government colleagues were very close to us. I say that in a positive sense, given the ambitions that we and the Government have for shifting the balance of care and providing care closer to home in the community. We talked about the financial aspects of that. We do not have bridging moneys any more, so the issue is how we secure that transition while making sure that patients are kept safe and how we build up community capacity while rolling down in-patient capacity, for example. From a

planning perspective, the Scottish Government has been very helpful to us.

Jim Crombie: Susan Goldsmith may want to talk about the NHS Scotland resource allocation committee formula.

Susan Goldsmith: We talked earlier about some of the demographic pressure that we feel in Lothian. One of the challenges for us as a board is that the NRAC formula, which influences the bulk of our allocation, works on the basis of relative population, so, as the population grows in the east and declines in the west relative to the east, we are perpetually trying to catch up with our share of the total pot of money. Almost year on year we are behind our target allocation. That clearly gives us a challenge, but we are in dialogue with the Scottish Government to recognise that that is an issue for us, and we will continue to be in dialogue with the Scottish Government year on year.

David Stewart: I have a final question relating to finance on Brexit. You have probably followed our discussions on Brexit in earlier committee meetings. One issue that I raised with the cabinet secretary, which I am quite concerned about, is the effect on reciprocal healthcare, such as the S1 and S2 schemes that Brits abroad get. There might be transitional support, but it is a real issue for new Brits going abroad that they will not get healthcare and may turn to NHS Lothian and other health boards. I know that there are Scottish figures on this. Have you in Lothian looked at the effect of additional social care and primary care demands from people who are currently living in the 27?

Susan Goldsmith: We are currently doing a piece of work to assess what Brexit might mean, so I cannot answer your question explicitly. That piece of work is under way.

David Stewart: Presumably you will put that into your high-risk category—I would if I were you.

Susan Goldsmith: Yes.

Alex McMahon: Absolutely.

The Convener: How does the NRAC shortfall that you describe relate to the £31 million gap between current and previous performance levels?

Susan Goldsmith: The £31 million relates to access targets. To achieve access targets we would need to spend an extra £31 million, although that would take us only to our March 2017 performance. The issue with NRAC is on top of that. It is to support all demographics.

The Convener: To achieve your full NRAC allocation, what additional funding would you have to receive this year?

Susan Goldsmith: By the time we get to the end of 2018-19, we will be short by about £14 million.

The Convener: Thank you very much.

Ivan McKee (Glasgow Provan) (SNP): Thank you for coming in this morning. I read through your submission with interest, specifically with regard to some of the areas of performance shortfall. I will come on to them in a minute, but there are just a few things that I want to work through first, picking up on some of the points that you made earlier. It was a very interesting introduction and I understand the challenges. Brian Houston spoke about the conundrum, and you referred a couple of times to the overall waiting list target and how you manage within that to make sure that individuals are not exposed in terms of where they are in that process. Does that suggest that, at the top level, we are measuring the wrong things if we are focusing on an overall target but, within that, there may be other things that are more important?

Brian Houston: Perhaps yes, but I will bring Jim Crombie in on that point.

Jim Crombie: That is always a question. As Sir Harry Burns characterised it in his report, are we hitting the target and missing the point? I think that there is an element of that and, if you spoke to clinicians, they would give examples of that. However, certainly in my opinion, there is benefit to us in delivering earlier access to treatment and to assessment. I think that that is an important principle. We have, however, recognised that we are in a different place from where we were before, with so many people waiting either for out-patient appointments or for in-patient treatment. We need to change our approach to managing this. Jacquie Campbell could talk through our approach and that might offer a bit of an insight into it.

Jacquie Campbell: As Jim Crombie described, we have recognised that the long waits on our out-patient waiting lists are a risk for us as an organisation. We have worked with our medical director to develop a clinical risk matrix that looks at services and the volume of patients on the waiting lists for those services in terms of the probability that the diagnosis of serious diseases could be delayed or that a patient's condition could deteriorate. On the back of that risk matrix, we have introduced a keeping-in-touch process, in which we actively contact patients who are on our waiting list. It gives the patient reassurance that they are still on that waiting list and it gives us an opportunity to assess whether there is any change in the patient's condition. It gives us the opportunity, if there is a change, to escalate the case back to the clinical team and potentially bring an appointment forward, depending on what is

said. We have also found through that process that there are a number of patients whose condition has got better, and they advise us that they no longer need to be on the waiting list, which has a benefit for other patients on the list, We are looking at this on a clinical risk basis.

Another good example is our endoscopy service. That is one of our high-risk services where we have worked with the clinical team to understand fully, from the consultant perspective, where our high-risk patients are. Although we look at and report on urgent suspicion of cancers, within that service some of our high-risk patients are those sitting in our repeat or surveillance queues, not in the new queue, and we have actively converted some of our capacity for those high-risk patients. We continually work with the clinical teams and calibrate our capacity to our high-risk patients.

Ivan McKee: There was a lot of good stuff in that response. Do you have a suite of measures that you use internally to understand the profile of what you have just described?

Brian Houston: Yes.

Ivan McKee: You are keeping track of it—that is good.

I move on to preventive spend. You talked about taking a risk, which I fully understand, and you mentioned diabetes and primary care. How well do you understand that risk? If you are putting in £X million and expecting £Y million back—Y being greater than X at some point in the future—how well do you understand the time phasing of when that will happen and what is the ratio between the input and the output? Do you have that experience or are you learning from other health boards in other parts of the world that are on the same journey?

Susan Goldsmith: We are developing our use of data metrics—Jim Crombie referred to that earlier—so I think that the answer to your question is that we probably do not understand it well enough currently. We know that we spend about 10 per cent of our total allocation on providing healthcare to individuals who have diabetes—they may also have other conditions but they have diabetes—so it is very much worth our taking a risk. We spend some money and we will not get the return for a long time, but it is almost a no-brainer. With the data that we are increasingly using, we will develop measures for that kind of investment in diabetes.

In primary care, we know what the demographics look like and what type of activity there is. We need to see providers in primary care and community services, so increasingly we will measure that. That is very much developing at the moment.

Alex McMahon: In Lothian we have about 35,000 diabetic patients, most of whom have type 2 diabetes, which can be prevented or reversed. The cost of treating that is about £110 million a year. There is a whole swathe of evidence that says that if we get people into dietary and weight loss programmes, and sustain them, we can reverse that number and that saving could be reinvested. That investment is absolutely a punt that we need to take, and we will do that with moneys that we get from the Scottish Government as part of the obesity weight management strategy that has been issued.

That is the kind of thing that we need to invest in as we go forward. The return on that investment at the level of individuals is huge, but it is also significant from an organisational point of view.

Ivan McKee: Another thing that has been mentioned is hep C; we have looked at that as well. I think that some work is being done on that in Dundee. If significant investment is made in that now, the incidence can be reduced to such a level that reinfection rates drop right off and quite a lot of money can be saved in the long run. Are you focused on that as well?

Susan Goldsmith: Absolutely. We try to channel our investments in a way that supports a reduction in the cost of the care that we provide.

Ivan McKee: I am interested in another area in your submission, which is about demand management. You referenced that in relation to accident and emergency, and there is a graph that shows quite a significant improvement. You have talked about things such as triage, flow centre and clinical algorithms. What are you doing on demand management across the piece?

Jim Crombie: We were showing a reduction in demand until the beast from the east arrived, and that blew our trajectories out of the water. That brings me back to my earlier point: we are challenged as a board—as we should be—to demonstrate effective use of the resources that we are allocated. We need to look not just at expanding capacity to meet increasing demand, but at the causation of demand and trying to reduce that. You have seen from the data some of the outcomes that are associated with the work that we have done.

I would be keen to hear from Jacquie Campbell and David Small about examples in which we are demonstrating an impact.

11:15

Jacquie Campbell: Ivan McKee mentioned the flow centre, which is a real success for us in NHS Lothian. We are now looking at that area on a regional basis, too. The flow centre works in

collaboration with the Scottish Ambulance Service, our primary care colleagues and the acute sector and looks at how patients can be diverted to the best place for their care. That may well mean that they go to an ambulatory care area, such as a rapid access clinic, rather than having to present to the emergency department. We have put in place a frailty hub that is based in St John's hospital, as part of the West Lothian programme; instead of having to present to the ED, patients have access to the clinical team at the rapid access respiratory clinic. The flow centre works very well in diverting patients to the right place for their care.

There is another real success story around demand reduction in gastroenterology, which is one of our pressured out-patient services. Working in collaboration with our laboratory colleagues, with the clinical team in gastroenterology and with our general practice colleagues, we went through testing and then full implementation of a new test that can be performed in the GP practice. That has reduced the number of referrals into secondary care by 400 a month. We have seen that as a sustained reduction. That is a good example of working collaboratively and reducing demand.

David Small: I can add some examples from primary care. At one level, there is the work that we are doing across the whole of Lothian; there is then individual work in each of the partnerships. Across Lothian we have our referrals advisory service, in which a GP works between secondary care and primary care on referral protocols for elective out-patient referrals to ensure that the most appropriate patients see the right kind of specialist. That is turned into an electronic referral process so that the GP can make the referral—the right referral to the right specialist—while they are sitting in the clinic. They also go through with the patient all the other things that need to be done before a referral is appropriate, because steps can often be missed and things can be dealt with in primary care.

We have a secondary care and primary care interface group, and a laboratories interface group, in which primary care and secondary care sit together and discuss issues such as the demand for tests and the taking of blood to ensure that we get the balance of demand in the right place for the right patients.

More locally, Midlothian is testing an enhanced triage system in two practices. In East Lothian, we have been piloting the Musselburgh access service, which is about same-day access, for 30,000 patients. There is early evidence that A and E referrals from the Musselburgh practices have dropped off as a result of that. These are early days, but we hope to be able to demonstrate that result.

In Edinburgh, physiotherapists have been put into practices to deal with musculoskeletal problems that can often end up in A and E, and with orthopaedics. West Lothian has been the lead area in Lothian on testing Scottish Ambulance Service paramedics doing home visits, so that those visits can be done quickly, on time, and by the right kind of person; again, that is being done to avoid A and E referrals.

Ivan McKee: That all sounds good. The final area that I want to touch on is the improvement process, which you have touched on already. You have also talked about data tracking. To my mind, that is about figuring out the drivers that are causing things and finding the biggest hitters. Then you figure out the action plan, and then you check to see whether it is working. You should then see your top line coming down, and you think, "Right, we've got all that stuff"—

Brian Houston: You have a job as well. [*Laughter*.]

Ivan McKee: How robust is that process? How recent is it—is it still being rolled out? At the very top level, how much of an improvement do you think can be delivered as you start to drive those improvements?

Jim Crombie: On the first question, we look at the process constantly and continually, and we look at reports weekly. Our ambition is to look at some of the demand issues daily, once our information system has evolved to where we want it to be; we certainly do that weekly, and absolutely monthly. We look at trends, so that if a new service—such as those that David Small and Jacquie Campbell described—starts we can identify and track the outcomes from it.

As David Small said, in East Lothian we are seeing early indicators resulting from the different approach to attendance at hospital. We are tracking that, and we will wait to see where it goes.

The process is consistent and continual, and if something is not delivering what we thought that it would deliver, we can look at that quite quickly to find out why.

I have forgotten what your second question was.

Ivan McKee: If that process continues, what impact do you see at the top level in terms of not only performance but financials? To be optimistic, if you are doing it right you should see a 1 or 2 per cent per year improvement there.

Jim Crombie: Susan Goldsmith might want to come in on that.

Susan Goldsmith: We referred in our submission to the development of our quality strategy. We have developed a quality academy, which is giving our staff the skills that they need

whenever they identify an opportunity for improvement; we will also provide additional data analysts, improvement advisers and project managers where required. That links into the triangle that we described in our submission and the improvement aspect of our longer-term financial strategy. We are at the early stages of that, but the board is absolutely committed to the roll-out of the quality academy across the organisation.

Ivan McKee: That is great. Thank you.

Ash Denham (Edinburgh Eastern) (SNP): I want to ask about delayed discharges and how they relate to the IJBs. We know that delayed discharge is an indicator of the success of the entire system and not just the discharge itself. In your submission you said:

> "There are specific and acute issues relating to performance within the Edinburgh Integration Joint Board (IJB)"

What is the board doing to support the efforts of the IJB in this area, particularly with long-standing delayed discharges? This is a serious issue and we are probably not seeing quite the progress that we would like to see here, so it would be helpful if you could talk about areas in which you have been doing things that might not have worked so well, and then say what you will do differently in the short term to address that.

Brian Houston: We agree with the question and the way in which you have framed it. The first thing to say is that it is a huge and recurring issue and we are extremely frustrated about it.

Jim Crombie: Ash Denham characterises delayed discharges as a major issue for the board, and I concur with that. I guess the first thing to say is we are not about characterising the IJB as the responsible officer for this. I agree with your view that it is a whole-system approach. Our approach to that has been to engage fully and in a supportive manner with the leadership teams in Edinburgh.

You will be aware of some of the demographic or socioeconomic issues that the city of Edinburgh faces. With relatively low unemployment, the ability to characterise or offer care jobs at a salary range that is better than what is offered for work in a supermarket or somewhere else has been difficult, because the care job is complex. It involves moving around. It involves dealing with individuals who might not be completely compliant and polite and, therefore, it is an environment that causes issues with recruitment.

Part of our approach is to say, "Join us for a care career. There is an opportunity for you to progress beyond that for which you are joining the organisation". We offer education and development to allow people to move forward. We are trying to exploit the integration that sees health and social care working together, so that people get an opportunity to flip across into a health career and move forward in that way.

Equally, we have identified tests of change, where we have tried to take care workers from the hospital environment and allow them to work with community and care colleagues with different models of care. We have tested that to see if it would work.

We have tried to look at the criteria that say, "How can we reduce the demand for care?" We are evolving rehab programmes so that we can maximise people's outcomes as quickly as possible to reduce that demand. David Small might want to give particular examples.

David Small: Edinburgh is in a difficult situation, and Jim Crombie has given a good explanation for the reasons—the strength of the economy and full employment. The implementation of the living wage is probably starting to help, but the next stage is to stick with that. The funding that the Scottish Government has made available has made that possible. It is really important for a career in care to be as financially rewarding as an alternative that might be available to people in an area of high employment such as Edinburgh.

Edinburgh has achieved some major successes. Compared to where Edinburgh was a year or so ago during the opening phase of the Royal Edinburgh hospital, when people were being delayed and the psychiatry-of-old-age beds were a critical issue, the situation has been transformed. A nurse-led team now provides rapid response for people who might otherwise become delayed. The bed numbers are now adequate for the demand that is placed on them because of the change that the integration joint board and the City of Edinburgh Council, working with NHS Lothian, have brought in.

On delayed discharges, the number of delays is important because each of those represents an individual person and a family. Length of stay is important. It is the number of bed days that delays are occupying that could be used for other forms of care. The average length of delay is coming down, perhaps not as dramatically as we would like but it is coming down steadily and that is an important figure.

I think that the Scottish Government has recognised that one of the six indicators for the integration joint boards that have been agreed is occupied bed days for delayed discharges, rather than the absolute number of delayed discharges, so I think we need to look at it in the round.

Susan Goldsmith: This is another area in which we have also taken a financial risk, because we have agreed with the City of Edinburgh Council

that we will make an additional £4 million available. Clearly we have attached some conditions to that. We want to see some improvement but, again, we have taken a financial risk because we know that part of the solution has to be about the investment that goes into that service.

Ash Denham: Do IJBs have a new strategy for getting additional provision into the system?

Jim Crombie: For the city of Edinburgh?

Ash Denham: Yes.

Jim Crombie: Yes, that is one of the major issues. A review is being done of the providers that are in play and offering care at home, on a locality basis and across the city of Edinburgh. It is exploring what the contract was expected to deliver and what it has actually delivered. Part of the issue has been provider failure, not just in the city of Edinburgh but across Lothian and beyond. Work is ongoing to find a real explanation of what causes system provider failure.

Ash Denham: You spoke about potential new models of care. Can you give an example of the sort of things that you are looking at in that area?

Jim Crombie: We are very keen on the concept of discharge to assess. That is a model of care that sees an individual patient who has completed their health treatment in an acute hospital but has residual needs. Currently that assessment process takes place in an acute ward; individuals who might not be dealt with as a patient in the community are taken forward in an assessment process. We are very keen to see how we can bolster our assessment and rehab service, so that primary care can be community-based and allow an individual to be discharged. We want that assessment and rehab to be put in place within their home, which is more realistic and more appropriate.

That takes me back to my earlier point that if we can reduce the needs of individuals, we can reduce the overall demand on the care service, and we are looking into that. Equally, we are looking at how we might sectorise the care provider so that there is a target within a community area. There is engagement within that area of care and health resource to look at how we might provide services in a truly integrated way. That is something that is being explored right now.

David Small: I can offer a couple of examples, if that is helpful. You have probably heard hospital at home being referred to by various other names, such as frailty model and so on, but we have tended to call it hospital at home in Lothian. Although its main function is to see people at home who might otherwise need to be admitted to hospital, its other function is to take people home from accident and emergency or medical assessment quicker than they might otherwise have done, thereby preventing them going into the system and becoming a delayed discharge. Hospital at home also often links with the discharge to assess process. They work hand in hand to make sure that people get the final stage of their care, which might otherwise be delivered in hospital, at home.

Our other innovation is hospital to home, which is NHS-employed personal assistants providing personal care as a transition or bridge between the patient getting home and the independent sector providers kicking in and providing the service. That has been implemented in East Lothian and Edinburgh, for example.

The Convener: I am looking at the numbers, though, and I am seeing more delayed discharges in February in Lothian than in the next two highest boards put together. That is a quarter of all delayed discharges—occupied bed days, as David said—in Lothian. Who is accountable for the failure to reduce delayed discharges?

11:30

Brian Houston: Who is accountable? The trite answer is that we all are. The chief executive of NHS Lothian, as the accountable officer, is accountable; the chief officer of the IJB is accountable and the chief executive of the city of Edinburgh Council is accountable. That is the model that we have set up so it is a shared accountability. At the end of the day, accountability still rests primarily with the chief executive of the health board as accountable officer.

The Convener: You have described a number of mechanisms to try to address the consequences of delayed discharge, but it is still about people coming into hospital and not coming out again, and many of those people coming in should not be coming in.

Brian Houston: It is. The practical manifestation of that accountability, of course, is the fact that the result of all of this and the failure to fully resolve the issue is that people end up lying in our acute beds in the Royal infirmary. They are not piled up outside the city chambers or anywhere else. They are occupying beds and, therefore, in a practical day to day sense, that is where the accountability starts.

The Convener: Given that, have you set targets for reducing that very large number and will you report publicly on the achievement of those targets?

Jim Crombie: We established performance trajectories in 2017-18 and we saw some of the evidence that has been cited by your colleague

when we saw a reduction in hospital attendance and admissions. We were tracking that very well.

However, the system has been hit with a series of provider failures in which anticipated capacity and resource could not be deployed. The characterisation of demand and capacity modelling in care provision and the information we are taking from that has only recently started to evolve. We are working now on 2018-19 trajectories to manage and monitor the impact of some of the changes and initiatives we have spoken to you about.

On reflection, I think city of Edinburgh faces a difficult journey ahead. The new leadership team takes up post at the beginning of next month. One of the earliest agenda items I will have with the new chief officer will be about how we can best move forward to improve the situation.

The Convener: Finally, before I bring in Emma Harper on the regional aspect, what is the relative cost of a delayed discharge person in a hospital bed versus that person in care provision at home?

Susan Goldsmith: It depends on the type of ward but about £1,000 to £1,500 a week. That does not take account of all the fixed costs and the infrastructure but it is of that magnitude.

David Small: A week in a care home costs approximately £600 to £700 but it depends where you are and what the rates are.

The Convener: You are talking about two to three times the cost and, therefore, a very significant part of that financial hit that you were talking about earlier.

Emma Harper: I am interested in issues around the health and social care plan for the region. The submission states:

> "The September 2017 progress report on the development of the plan highlighted a degree of frustration that work on the propositions included in the plan made marginal improvements to existing models of care"—

which is similar to Ash Denham's point about IJBs—

> "rather than generating the genuinely transformative propositions to deliver ... disruptive innovation".

It is interesting to read the word "disruptive". I know that change is disruptive, but is there a culture of people who are early adopters or change agents as well as naysayers who you need to drag along in the change? What is the plan for regional issues as we move forward with IJBs?

Jim Crombie: Your characterisation of individuals' approach to change is well rehearsed. There will be individuals who will immediately and enthusiastically embrace the concept, because they see the outcome associated with a change. There is a spectrum, down to individuals who, no matter what the outcome is, will just disengage because change is so full of angst for them. We all recognise that that is part of NHS provision and has been for the past 40 years, so we need to accept it and move forward.

The most up-to-date report from the region characterises movement and improvement. However, we have a limited ability to introduce significant change to generate savings. I mentioned earlier the south-east region being characterised as an area of growth, with a 10-year demand model showing a 45 per cent increase in out-patients and a 35 per cent increase in A and E attendances, with those continuing to increase. That is an issue. The boards in the south-east of Scotland have gone through a disruptive transformation in acute services. We have reduced the number of sites, the number of A and E departments and the number of hospital beds. We have tried to move our acute specialties on to one campus, rather than have them provided on different campuses.

There is the opportunity to consider whether we could centralise a specific specialty to a specific area and disengage that process from a locality. That is significantly disruptive, and I guess that it will be part of our programme as we move forward, in considering real alternatives and real challenges to the paradigm.

Susan Goldsmith: I will give one example, because we need to have early examples and give confidence. We have just agreed that we will have one operational management board for laboratory services across the south-east. That will eventually bring about a change in how we deliver laboratory services across the region, using new technology that means that we do not have to have every service on every site. Again, we are at the very early stages but, if we can deliver that, that will create confidence in the change agenda. However, that is not going to save us lots of money; it will allow us to continue to provide the service.

Jim Crombie: I would also cite an example around radiology. One of our sister boards had a real issue with its ability to recruit radiologists. The clinicians as a team—those from NHS Borders, NHS Lothian and NHS Fife—considered how, as a region, we could best provide support to NHS Fife. We decided to use PACS, the picture archiving and communication system, which allows images to be acquired in one location but examined in various locations, to try to deal with the clinical issues around provision in Fife. However, one issue was that, if an NHS Lothian radiologist looked at a report generated in Fife and reported on it, that would go on to the NHS Lothian reporting system. Working with the supplier, the e-

health team and others, we developed a prototype that allows such a report to be generated in the host board system. That has seen real stability being brought to bear around the provision of radiology.

That is a good example of where clinician-led regional working has resulted in an ability to sustain a service, which I think will be a theme as we go forward.

Emma Harper: There are certain pathways that are currently in process. For instance, Dumfries and Galloway is considered part of the east cancer pathway, which is bizarre, because Dumfries and Galloway is not in the east of any region and it means that Stranraer folks have to travel to Edinburgh for radiology as part of the managed clinical cancer network. As part of regionalisation, other boards will have to move services and pathways to other areas, for instance. Does that affect the ability of the boards in planning? Does it put further pressure on other areas?

Jim Crombie: I guess that all that needs to be tested. We work closely with the other regional groups. Ideas or issues or disruptive changes that are being developed and evolved in the west would be subject to discussion with us in the east and with our colleagues in the north so that we really understand not just the impact there but the possible ripple impact on other boards. There is a process of engagement and collaboration, so anything like that would be tested.

Brian Houston: It is worth adding that the current overlay of the regional structure, which has been in place now for a year to look at planning from a regional perspective, has been fairly roughly hewn. It was put in place fairly quickly. A lot of people recognised that there were anomalies, overlaps and perhaps gaps in the way that the lines had been drawn between east, west and north. As Jim Crombie says, that is being reconciled pragmatically by making sure that we all stick together on the issue and talk to each other about it. You can well imagine that, as the regional initiative develops and gathers strength, there will be further revisions and honing of regional boundaries and definitions as we go forward.

Alex McMahon: On the cancer point, regardless of the regional work, in reviewing the cancer centre and its provision, a lot of the focus is on how we can provide care closer to home so that people do not have to travel from Dumfries up to Edinburgh. Obviously, we provide a facility for people to stay overnight, which is great, but we are considering how much of that could be repatriated back to the other board. The issue will be picked up through the regional process, but there is another process through which such issues will be flagged as well.

Emma Harper: Do you mean things such as radiotherapy being disseminated more rurally?

Alex McMahon: It would be dependent on each pathway, which you talked about. We are considering what can reasonably be done at a local hospital versus things that need to be done in a centre—the more specialist high-end stuff. It would be the more routine treatments that would be provided more locally.

Jim Crombie: The oncologist would be clear, though, that the cancer journey should be within a team and a recognised network because, if elements are undertaken outwith that network, there can be differences in approach and different protocols, with an increased risk for individual patients. It is not as simple as taking a part of the journey of the cancer clinical pathway and moving it around; it is about looking at the whole process and saying, “How can we best offer a service?” As Alex McMahon said, our ambitions on our new regional cancer centre will see us engaging with all current users and all boards to see whether a better pathway can be evolved as part of that development.

The Convener: That has been a very full session. I thank colleagues for their input and our witnesses for their evidence. My apologies to my colleagues who still had questions to ask. We will write to our witnesses with a follow-up letter, probably in the course of next month, and no doubt some of those additional points will be raised in that letter, but it will also pursue some points from the evidence that we have heard today.

11:42

Meeting continued in private until 12:02.

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

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