OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 8 May 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 8 May 2018

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HEALTH AND SPORT COMMITTEE
15th 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:

Dr Jennifer Armstrong (NHS Greater Glasgow and Clyde)
Jonathan Best (NHS Greater Glasgow and Clyde)
John Brown (NHS Greater Glasgow and Clyde)
Jane Grant (NHS Greater Glasgow and Clyde)
Mark White (NHS Greater Glasgow and Clyde)
David Williams (Glasgow City Health and Social Care Partnership)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 8 May 2018

[The Convener opened the meeting at 10:00]

Scrutiny of NHS Boards (NHS Greater Glasgow and Clyde)

The Convener (Lewis Macdonald): Good morning and welcome to the 15th meeting in 2018 of the Health and Sport Committee. I ask everyone in the room to ensure that their mobile phones are off or on silent. You are welcome to use mobile devices for social media purposes, but please do not take photographs or record proceedings.

The first item on our agenda is an evidence session with representatives of NHS Greater Glasgow and Clyde as part of our programme of scrutiny of national health service boards.

I welcome to the committee from NHS Greater Glasgow and Clyde John Brown CBE, who is the chairman; Jane Grant, who is the chief executive; Mark White, who is the director of finance; Dr Jennifer Armstrong, who is the medical director; and Jonathan Best, who is the interim chief officer of acute services. David Williams is the chief officer of Glasgow city health and social care partnership.

I invite John Brown to make an opening statement.

John Brown (NHS Greater Glasgow and Clyde): Thank you for the opportunity to share the work of NHS Greater Glasgow and Clyde.

The convener has introduced my colleagues. I want to pause before I start and put on record how privileged I feel to have such a strong senior leadership team. NHS Greater Glasgow and Clyde is the largest of the Scottish health boards. In fact, it is the largest healthcare organisation in the United Kingdom. To have such a strong leadership team makes all the difference to the role of the chair and the role of the board.

Being such a big organisation, we submit documents to committees to explain our business. It is a considerable amount of information to try to get across. I hope that the documents that we have submitted give the committee some insight into how the board has responded to the challenges that are faced by healthcare providers across the UK.

The documents mainly describe the current situation, but as the committee is well aware, the changes in demographics, the ageing population and many other factors, including the shortage of some specialist clinical skills, mean that all health boards have to change if we are to continue to deliver the high quality services to which we aspire.

I hope that the committee does not mind my using some notes. I will try to keep my remarks fairly short. When I looked at some of the presentations that other boards have made to the committee, I was interested to see how short some of my colleagues managed to make them. Unfortunately, because of the size and complexity of NHS Greater Glasgow and Clyde, mine might be a bit longer than normal. My notes will keep me on track.

Before looking at our plans to transform health and social care to meet the increase in demand on the system, I will spend a couple of minutes, if the committee does not mind, describing who we are and what we do, in context. We serve a population of 1.1 million people across six local authorities, which is one of the reasons why there was so much briefing paper. We employ about 39,000 people and are the biggest employer in Scotland. We are located across 10 hospitals and 61 health centres, and have about 115 care homes. We have 237 general practitioner practices and, given where we are positioned geographically, 87 of them are in the top 100 most deprived areas and are deep-end practices: I am sure that the committee will be familiar with that concept. We are responsible for a big organisation with an annual budget of more than £3 billion of taxpayers' money. We represent almost 25 per cent of NHS Scotland.

There is a large demand on the system and a large number of patients, service users, and their families and carers look to us to support them. There are almost half a million visits per year to our accident and emergency departments, which is disproportionately high for our population.

We have more than 200,000 scheduled in-patient appointments and 1.1 million out-patient appointments in a year. Every year, 5 million people in NHS Greater Glasgow and Clyde go to their GPs and we deliver more than 15,000 babies. In our part of Scotland, 24 million prescriptions go out.

NHS Greater Glasgow and Clyde is not just about the geographical patch that the six local authorities cover. We also provide specialist services for all Scotland or the population in the west of Scotland. We have facilities such as the national spinal injuries unit. Paediatric intensive care is delivered on a national basis. We also have the Beatson west of Scotland cancer centre.

We are also a significant training board. We do more than simply deliver services: we continue to grow the capability and capacity for NHS Scotland. We have approximately 1,300 doctors in training at any point in time across the board and we support 800 medical students.

NHS Greater Glasgow and Clyde does a lot of good work with the universities. We do a lot of clinical research. We work closely with the University of Glasgow and Strathclyde University. We also work with the private sector and deliver more than 900 clinical research studies in a year. We are at the forefront of research and development.

I would like to think that we are at the forefront of the work to implement the health and social care delivery plan. Our priorities—our four key aims—are better health, better care, better value and a better workforce. You will have seen the triple aims. A number of organisations' papers describe them as better care, better value and better health. We have put better health first on our list because of the priority that needs to be given to prevention and improving the population's overall health for the future. We have added better workforce because we recognise that making NHS Greater Glasgow and Clyde a good place to work—in fact, a great place to work—will help us to recruit and train the best quality staff.

That is who we are and what we do. The real question is what needs to change—what we are going to do differently. We want to move from treatment to prevention, so there is a real emphasis in NHS Greater Glasgow and Clyde on public health. We want to maintain and, where possible, improve safety, our performance and the quality of care. One of the big challenges that faces all health boards in trying to move to a new system of integrated health and social care is how to move resources out of acute care to primary and community care.

The health service is no different from every other part of the public sector and we have to live within our budget allocations. I am pleased to say that, this year, we once again delivered a balanced budget. Given the size of the budget and complexity of the system, that is no mean feat and it is a credit to my colleagues on the senior leadership team. Our expectation is that we will do likewise this year. It is never easy to live within your means in the public sector. I have been in the public sector for 45 years and that challenge has always existed. Every year, it gets harder.

For us to stay in financial balance, it is realistic for the taxpayer to expect us to be as efficient as we can be with the resources that we have. Therefore, we have done a lot to reduce our costs, reduce waste and improve productivity in the current system. That is a continuing process. In the current year, we look to save around £40 million to £50 million by being more efficient. We think that that is doable. We have a good track record in that regard. Last year, our overall efficiencies were just above £60 million, £40 million of which came out of the acute services.

In addition to being more efficient in the current services, we are also looking for how we can do things differently and how we can deliver the new system. We have invested a lot of time, energy and thinking into a transformation programme, which we call moving forward together. It is called that to emphasise its inclusive nature. It has been designed by our clinicians. The involvement of our staff is important to us for getting the design right but the involvement of our patients, service users or their representatives is equally important. That is why this meeting is a good opportunity for us to talk a wee bit about what we are doing as we look forward.

As you would expect, the approach is based on an analysis of the population's existing and future needs, and it is very much research driven. It also brings into play the latest thinking on best practice in health service delivery, not just in Scotland but across the UK and wider, and it conforms to and supports the direction that has been set by the health and social care delivery plan.

Dr Jennifer Armstrong is our medical director and the person whom we have asked, quite rightly, to lead on the redesign of the service. She has been working with colleagues across the different specialties and clinical groupings to look at what is the best way to deliver the service in the future. I am sure that Jennifer will be happy to talk more about that.

We are not simply looking at what to do from the NHS Greater Glasgow and Clyde perspective. In line with the health and social care delivery plan, we are also looking at what we can do to support national and regional changes. Being the biggest resource within NHS Scotland, we have a big part to play in it, and all members of my senior team have been involved in national and regional planning work. A good example of how we are taking that forward nationally is that we are looking at developing a major trauma centre for the west, adopting a more regional approach to cancer services and introducing a west of Scotland renal transplant service.

There are, of course, pros and cons to working with our colleagues to develop what is probably best described as a population-based approach to delivering services. Some services will be centralised into centres of excellence, which will make them physically less accessible in the sense that they are perhaps less local, but they will provide better-quality service and better outcomes. An issue for us is how we get the public on board

with understanding the benefits of those changes and engage with them at the earliest possible stage in the design of services, so that they will meet people's needs as well as being delivered more efficiently and effectively. We have to get that balance right.

Of course, when we look forward, we must not take our eye off the ball in the here and now. We recognise that we need to do more in our current services, and a lot of energy goes into trying to improve current performance. Our written submissions show the committee that we need to do more with elective work. An example of an area in which we are doing a lot to raise performance is the number of patients who are waiting longer than we would like before they start their cancer treatment—the 62-day target will be familiar terminology. We are putting a lot of effort into that area. We have also done a lot of work over the past year to improve on unscheduled care. We have stabilised our performance at the front of the hospitals, but it still needs to improve. Our chief executive and chief operating officer will be more than happy to talk about any particular issue concerning our current performance.

I am also pleased to have David Williams with us. He is chief officer for the largest of the six health and social care partnerships. David is happy to talk through any health and social care partnership issues, the setting up of all six integration joint boards and so on.

Having six local authorities, six health and social care partners and six integration joint boards brings challenges as well as opportunities. Since the HSCPs and IJBs came into being, we have put a lot of energy into ensuring that their work and that of the health board and council are all consistent, heading in the same direction and integrated. In particular, we are ensuring that the integration joint boards are supporting the delivery of the health and social care delivery plan and its aims and objectives.

The integrated approach obviously presents a governance challenge. It is an integrated organisation with more governance boards than before, so we have reviewed and revised our approach to governance to bring together the full system at the sub-committee level within the boards. I can talk more about that, should you wish to find out more of the detail.

10:15

The Convener: You have laid out quite a number of the challenges that we will explore with you. You talked about the need for change. One mechanism for achieving change is the annual accountability review, which sets out what you need to do in the short term—over 12 months—to improve performance. Alex Cole-Hamilton will ask a couple of questions about that.

Alex Cole-Hamilton (Edinburgh Western) (LD): I will focus on waiting times and particularly the 12-week guarantee. The 12 weeks have been exceeded for in-patient and out-patient appointments; in both cases, the number of people who have waited for more than 12 weeks has doubled in the past year. The committee understands and accepts that a principal reason for a waiting time delay in any health board area is that demand vastly outstrips supply. One of the biggest interruptions to supply comes from delayed discharge, but you are the best-performing health board at reducing bed blocking—delayed discharge. That does not scan. What is the cause of the delay in treatment for all those people if it is not delayed discharge?

John Brown: You are right to identify that the challenge is in how we match our resources to demand and in the different demands on resources across the piece. I invite Jane Grant to talk in more detail about the work that she and her team have done to provide a baseline for our capacity, to improve and increase capacity to meet demand better and to target our resources to the particularly high priorities in the treatment time guarantee space.

Jane Grant (NHS Greater Glasgow and Clyde): I will give an overview and Jonathan Best, who deals with the issue day to day, will give some insight. As the chairman said, balancing elective work with unscheduled care demand has been a challenge for us, as members can see from the figures. This year, we have spent time on looking at our baseline capacity. We have looked at the number of clinics, the clinic templates and the demand profile. That differs for each specialty. Some areas have had a significant gap, which we have been covering on a non-recurring basis for a number of years. The challenge is to get to a recurring balance.

It has taken us a little while to get to the absolute detail of the number of theatre sessions, the number of clinics, when they start and finish, and what that looks like. We are now well down that road and we have made significant progress on establishing our baseline capacity.

Alex Cole-Hamilton referred to delayed discharges, but the issue is not all about beds. It is all about beds in some areas, where we have work to do, but we have done a lot of work—David Williams and others might pick up on it—with the six partnerships and the board to deal with delayed discharge. As Alex Cole-Hamilton said, our performance on that is good.

The capacity gap in in-patient and day cases relates to much more than just beds; it is about our

resources, theatre sessions, manpower and workforce. We must look at our workforce and physical capacity. Our focus has been on ensuring that we have an efficient service and that we can prove that the productivity and efficiency within our baseline are correct. We are looking at redesigning pathways and doing things differently, as well as traditional additionality. We believe that that tripartite approach will get us into a much better position this year.

Does Jonathan Best want to add anything?

Jonathan Best (NHS Greater Glasgow and Clyde): I have a couple of things to add. Jane Grant is right that we have stepped back and done a root-and-branch review of our capacity and how we can fit that to the demand that is being referred to our hospitals. We have taken each specialty and looked at the number of clinics over a year and at the position consultant by consultant. We have looked at our ability to maximise the use of clinic slots and sessions and we are looking at ways to redesign provision.

An exciting opportunity comes from the modern out-patient programme, which the committee will be familiar with. Under that programme, we have a number of streams of work going on—for example, patient-focused booking is giving the majority of patients a choice about when they come to hospital. The opt-in process through our referral management centres is proving popular; it avoids wastage of appointments and allows us to maximise what we provide to patients.

Alex Cole-Hamilton: The health boards that seem to do best at managing patients who are waiting longer than 12 weeks are the ones that capture at a granular level the reasons why people are waiting longer than the guarantee. They set them up in a register and then talk about what they are going to do to mitigate the problems or interruptions in the future. Do you do anything like that?

Jane Grant: We look at waiting lists regularly. We look at the urgent slots and make sure that patients who require urgent care are dealt with first. We make sure that we look at the cancer slots to ensure that we have enough capacity. Our board's access policy is clinical priority and then date order. One of our challenges is that NHS Glasgow and Clyde is a big organisation, so we have a number of places where people can attend for, for example, an orthopaedic appointment. Sometimes demand does not balance with capacity in the specific sector.

We have to be cognisant of the fact that people in Clyde might not want to travel to Glasgow royal infirmary. We have a bit of work to do to smooth the pathway and make sure that patients have some choice but also quick access to services within their local area when they need them. We are doing some work on that just now. Jonathan Best may have something to add.

Jonathan Best: I have a wider example. As the committee knows and the chairman has mentioned, we provide services for the region and also some national services. We also support NHS Western Isles. We did a recent pilot using telehealth and videoconferencing.

One of the orthopaedic surgeons at Glasgow royal infirmary now holds his whole-day clinic via videolink to the Western Isles, where a physiotherapist or specialist is with each patient. It is a whole-day clinic and it means that all those patients do not have to travel to Glasgow. From a list of 20 to 30 patients, seven were listed for surgery, and that is a good and efficient way of running the service. We need to do more of that, so that we are not only managing the lists but how people come to see us and how we anticipate their needs.

Alex Cole-Hamilton: I am also keen to hear about expectation management. As MSP for Edinburgh Western, I get a steady stream of constituents through my door with letters from the health board that say that they have been scheduled for surgery or treatment of some kind, and that they can expect by law to be seen within 12 weeks but sometimes exceptional pressures mean that that slips. A few weeks later, they get another letter to say that it will not be 12 weeks and they are going to have to wait nine months. There is something very cruel about that expectation management, and I have taken that up with NHS Lothian.

How do you manage expectations when you know that you are likely to miss the 12-week treatment guarantee?

Jonathan Best: You are right. Our patient management system generates such letters automatically and makes sure that the correct date is given to the patients. In Glasgow in the past year, we have changed our correspondence with patients to be much more up front and open about when appointments will be.

It is important that we also provide advice lines and phone numbers so that patients can speak to someone—not just a receptionist but one of the specialist nursing staff or a doctor—if they need to discuss their condition. That is beginning to bear some fruit, but it does not detract from the fact that it is a longer wait for some patients.

The Convener: The cabinet secretary set some specific targets for this current year. She said that the waiting times standards for out-patients and in-patients should be no worse than they were last year and that the four-hour accident and emergency wait at Queen Elizabeth hospital

should be achieved in at least 92 per cent of cases. NHS Greater Glasgow and Clyde missed all those targets and patterns have gone in the opposite direction. Was the cabinet secretary unreasonable in setting those requirements?

Jane Grant: As we explained, the elective position has been difficult. There is no doubt about that. The whole of Scotland has found it difficult. We have spent some time trying to build baseline capacity. If we keep on adding more and more, we will never crack the problem. We have spent time this year trying to establish what capacity we have.

We recognise that there is a lot to do and that there are a number of initiatives that we have already talked about to try to deal with that. We have looked at the operational plan for this year and signed up to returning to the March 2017 position, with the exception of the out-patients target, which we are going to try to do over two years, because it is very significant. We have to balance that with the emergency department target, and we are making sustained progress with that, albeit that the increasing demand coming through the emergency flow is proving somewhat challenging.

We have work to do through our unscheduled care steering group across the board, which includes partnerships to try to change those demand profiles. Given the size of greater Glasgow and Clyde, the complexity of that picture should not be underestimated, but we recognise that we have work to do.

The Convener: Do accountability reviews drive performance for the board?

Jane Grant: They do. On the feedback that we have received, at one level, it is helpful to see that the things that came back from the accountability review are the things that we are paying attention to. We recognise that they are challenges for the board so we were working on them anyway. However, we absolutely recognise that it is important to be accountable in the public domain for those areas in which we need to do better, and we are working really hard to do that.

The Convener: If we take this year as an example, what happens when you are set targets for the following 12 months as part of the accountability review, and you do not meet those targets? What is the consequence of that?

Jane Grant: This year, we have set more detailed trajectories so that we can see clearly where we should be on a monthly and quarterly basis. Last year, we spent more of our time trying to establish the base capacity and looking at some of the base issues, whereas this year we are quite clear about the trajectories and what we have to do, so we can see whether we are ahead or behind and whether the actions are delivering what we have set out to do. In some areas that is easier said than done, because causes and effects do not represent direct impacts. However, this year, we have clearly set out the actions and the trajectories in a more detailed way, and that will give us and the board the ability to see much more swiftly—very early in the year—whether things are going awry.

The Convener: Does the direct involvement of ministers in the accountability review make a difference to the outputs and indeed to the responses from the board?

Jane Grant: Yes, certainly. We work closely with the Scottish Government all the time, and having the minister there certainly focuses the mind on the key priorities. I have also been involved in non-ministerial reviews of the same key issues in other boards. That focus is also important, but having the minister in the room certainly focuses the minds of everyone in the team.

The Convener: Okay—thank you. We have touched on delayed discharge, but I know that Ash Denham wants to follow up on that.

Sandra White (Glasgow Kelvin) (SNP): Convener, may I ask a supplementary question?

The Convener: Please be very quick.

Sandra White: Good morning. I want to pick up on what Alex Cole-Hamilton asked about. He mentioned people coming along whose operations have been delayed or cancelled. You are looking at new policies in that respect, but do you advise such people that they can be put on another hospital's waiting list? Is that part of the information that you give? I do that: I phone up other areas to see whether there is a vacancy and whether a patient can go there.

Jonathan Best: We do advise patients of that. We have that conversation with the patient at the consultation. Some choose to wait and some do not. In many instances, patients want to stay in their locality; for example, many folk in Greenock prefer to go to their local hospital. However, we offer services across our range of hospitals in greater Glasgow and Clyde, because we have, for example, orthopaedic departments in most of them. As Jane Grant said, the key issue is clinical priority, and then we see people in date order. However, we do have those conversations with patients.

Sandra White: Okay. I note the peaks and troughs in your figures on out-patients and waiting lists. When there is a flu epidemic, that will affect your targets. That is the reason for one of the peaks in the report that we have. Obviously, if the beds are full, people cannot be admitted. Are things such as flu epidemics taken into account?

Jane Grant: This year, we have had one or two short periods when we have had substantial additional demand and had to cancel some patients' appointments to ensure that we had enough capacity—in terms of both beds and workforce—to deal with patients appropriately. However, those times have been short. We are working hard to mitigate that and to ensure that we get back the patients who were inconvenienced during that period. We are working hard to rebook their appointments as soon as possible. However, there were undoubtedly one or two challenges this winter, for short periods.

10:30

Ash Denham (Edinburgh Eastern) (SNP): It is clear that you have made really good progress on delayed discharges, but other boards are struggling with the issue. Will you share actions that you have taken that have succeeded in reducing delayed discharge and which might be of use to the boards that are struggling?

Jane Grant: In NHS Greater Glasgow and Clyde, we have addressed delayed discharge as a whole-system issue between the acute system and the partnerships, because we believe that it is a whole-system issue and that it does not relate to just one part of the domain. If we do not have efficient processes for identifying patients early when they are in hospital, that leads to delays. In addition, if we do not have a good dialogue with our partnership colleagues, they will not anticipate the patient profile that they will have to deal with.

David Williams and colleagues work closely with corporate directors in the board to ensure coherence across the area. He will talk about one or two examples that he has been involved in.

David Williams (Glasgow City Health and Social Care Partnership): Performance in Glasgow is good, but we are never complacent. An incredible amount of hard work is required to keep on top of performance and the demand that is continuously in the system. As Jane Grant highlighted, there is joined-up working between the acute system and partnership workers and managers; we also engage and involve provider organisations—particularly those from the independent sector—that offer placements in care homes and care-at-home provision.

That ensures smoothness in the system, but the granular detail of knowing patients is key to keeping on top of patients' progress through hospital. As I said, that requires hard work, and people are committed to achieving the best performance.

The six partnerships in the NHS Greater Glasgow and Clyde area have invested in a number of provisions to assist in that. Glasgow city health and social care partnership and one or two other partnerships have intermediate care beds that are designed for the reabling process and approach, which assists and supports patients in going home—because most people tell us that they want to be at home—rather than over-65s and older populations having to assume or conclude that they are heading to a residential care bed or a nursing care bed.

To deliver that approach, we have changed our thinking and moved away from assessing people in a hospital bed for their long-term care needs. It is important to have early referrals so that social work staff can meet families and individuals and begin to assess at a low level whether the person can go home, with or without home care support, or whether they need to go into intermediate care because the assessment process is a bit more convoluted and complex and their needs are a bit more complex.

We set targets for delivery and achievement. In intermediate care beds, we have set targets for completing reablement and rehabilitation in a maximum of 30 days or thereabouts. We strive to get about 30 per cent of the people who go into intermediate care beds home, although we recognise that such individuals have complex needs. The performance regime that we have in place to deliver that is important.

We are doing hard work and there is joined-up working between the acute system, partnerships and the independent and voluntary sectors, which are part of the process. Genuine partnership working is taking place and is the essence of the integration agenda to transform health and social care delivery.

Where we are able to invest in new models of provision, we should do that. It requires some challenge in the system, which is more difficult for some other areas across Scotland. For instance, smaller partnerships may wish to invest in intermediate care beds and require only three or four beds to make a big difference, but registering those beds in a care home that is a long-term permanent home for its other residents can be a challenge, so the response has to be variable. The key to the system impacting positively for a big complex health board such as NHS Greater Glasgow and Clyde is for the six partnerships' chief officers to work together and strive to achieve consistency across the piece, so that their work is not in conflict and does not impact negatively on the system.

Alison Johnstone (Lothian) (Green): I represent Lothian: NHS Lothian is not without its challenges when it comes to delayed discharge. Is it easier for NHS Greater Glasgow and Clyde to get hold of property, and is that why it is more affordable to deliver care home provision there?

Why are you finding it easier to get staff? You are clearly having greater success than many health boards, and I am wondering how well that best practice is being shared. Is it the case that one size will never fit all, and that what you are doing in your neck of the woods cannot be replicated in other areas, or are there lessons that can be learned?

David Williams: There are, absolutely, lessons that can be learned. That said, I do not believe that there is a one-size-fits-all approach for the partnerships in Scotland. As I have said, intermediate care provision will not be applicable in some areas, for reasons of scale and because there are other more appropriate responses. In Glasgow city, in particular, and more broadly in the six partnerships across NHS Greater Glasgow and Clyde, there is a bigger population from which to draw for recruitment, so there are fewer challenges in that respect.

There are issues around availability of care home provision. Not very far back, there was overprovision of care home facilities, which is still the case in Glasgow city. That probably to some extent reflected land values in the west of the country, especially in the city, where property could be developed and built more affordably than was the case in other parts of the country.

At one stage, not long ago, there was an assumption by developers that the route out of hospital was, de facto, straight to a residential and nursing care business, and that the local councils would pick up the tab for that because there were fewer self-funding patients in that cohort. A business was already developing, if you like, which is one of the reasons why we changed the assumption that we would do assessment at the hospital bed, and would strive to deliver on shifting the balance of care to support more people to continue living at home, and recognise that some people will recover.

There is also something to be said about the availability of a workforce. In Glasgow city, and the Greater Glasgow and Clyde NHS board area more generally, wage levels are different to what they are in the east. The cost of living is higher in the east and parts of the north-east, where there are some issues, which I think is a reason why the Government has attempted to address that with the Scottish living wage and is trying to ensure a more appropriate level of remuneration for the workforce.

Alison Johnstone: I suppose that there are conditions that are particularly favourable to delivery of social care. I am thinking about casework in which I have been involved in Edinburgh. For example, a patient was kept in hospital for several months simply because adaptations could not be made to his home. He had lived in a tenement to which he could not return, and there was a long wait to provide accommodation. It sounds as though that kind of thing would be less of an issue for you, so I would like to hear your views on that.

Your campaign on the power of attorney also seems to have had a big impact. We are aware that some cases in which people are kept in the wrong place for a very long time have to do with that legal issue. It is not an infrastructure matter; it is about public education. Could you touch on that?

David Williams: On the first point, we are by no means perfect, and we have such issues from time to time. In Glasgow, there are particular issues to do with the fact that tenemental properties make up the majority of the housing stock in the city, which can create challenges for many people because, for example, it is not easy to install a stair lift in a communal close. Such things have an impact, which is why we do not always have a zero figure for delayed discharge. It is also why, in the acute system, we have some lengthy delays, particularly in the under-65 age group, where the issue is more likely to involve a physical disability, which means that there will be a need for adaptation.

On the power of attorney campaign, four or five years ago, we used some of the change fund money that was available to run a joint campaign with the health board in the partnership. That campaign was well received. The idea was quite deliberately to recognise that some patients do not themselves have capacity and capability to make a decision, and so can be delayed in their recovery journey because of the need for a decision to be made for them. The power of attorney is a relatively quick and speedy process that means that there is no need to use the lengthy and protracted welfare guardianship process. It is seen as a preventative and early intervention approach that is of benefit to us all—not just older people. That is the message behind the power of attorney campaign.

I should say that that is something that chief officers of health and social care partnerships across the country have recognised. A matter of weeks ago, the health and social care chief officers network, which is the national collective of chief officers, agreed to progress a national power of attorney campaign. Each partnership will contribute financially to the development of a national campaign that should positively impact across Scotland. Glasgow city health and social care partnership is leading that process for the other partnerships, and we are currently working to develop the procurement framework for delivery of that campaign.

Alison Johnstone: From your work across six local authority areas, do you know whether there are peaks and troughs in terms of some areas having greater challenges than others?

David Williams: It is a peaks-and-troughs business: Jonathan Best alluded to the fact that demand goes up and down. If demand goes up at the front door of the process, that will flow through to the discharge process and to the number of individuals who are involved.

Alison Johnstone: Are there geographic differences between the local authorities?

David Williams: Jane Grant mentioned whole-system working, and we try to keep on top of that. The nurse director for the health board has co-ordinating responsibility for ensuring that we all keep abreast of our responsibilities and have them at the forefront of our minds. As I said, we are in that granular realm of knowing patients and looking at things case by case. That approach covers all six partnerships, and we are absolutely clear about the need for that.

The Convener: The Scottish Government has set out a general target of zero for delayed discharge. Your performance is relatively strong, but you have still lost 4,300 bed days in the current year, so is there any prospect of achieving zero at any point?

10:45

Jane Grant: We are working, as David Williams has said, to minimise the number. It has come down in the past few months. The occupied-bed days figure has reduced further. We need to pay attention to all the things that he described, and to mental health delays. We are working collectively with other health boards—NHS Lanarkshire and NHS Ayrshire and Arran—on the delayed discharge patients whom we have from them, as David Williams described for greater Glasgow and Clyde.

We will continue to make progress and will give the matter the attention that it needs. Patients need to be treated in the optimal situation for them. We will do our absolute best to reduce towards a figure of zero.

The Convener: Mention was made earlier of the 62-day cancer wait. Emma Harper has questions on that.

Emma Harper (South Scotland) (SNP): I am interested in cancer waiting times. I know that NHS Greater Glasgow and Clyde is working with NHS Lanarkshire, NHS Ayrshire and Arran and NHS Forth Valley as part of the regional cancer network. There are discussions about other networks, for example in relation to NHS Dumfries and Galloway. It is currently part of the east network, but Stranraer does not consider itself to be in the east of the south of Scotland. That might produce challenges.

What are the reasons for the worsening of the cancer waiting times? It is important that, when people are diagnosed, they get treatment within 31 days and that, where there is a suspicion of cancer, they get further care within 62 days. What key factors are causing the delays?

Jane Grant: I will pick up on the high-level picture and Jonathan Best will provide the detail.

You are right that we work in a regional context for most of this area, and there is debate at the regional level about the optimal pathways for patients, whether within the current west configuration or within Dumfries and Galloway and other areas.

We are doing reasonably well on the 31-day target—we more or less hit that all the time. There are one or two areas where we have not, but generally we do well on that target.

On the 62-day target, we have to be clear about the pathway for patients. We have to make sure that we are identifying those patients and tracking them properly at the beginning, that the time to the first out-patient appointment is optimal and that the tests and surgery are also optimal.

If it is not tracked with consistent targets breaking up the pathway, when we reach 61 days and find that surgery is needed there is a very small amount of time left. We are trying to break the pathway into chunks to make sure that, if people are behind in their pathway, we are on to that early, rather than waiting until there is a cumulative impact.

In each specialty, there are different issues. There is not just one reason for delays. I will let Jonathan Best give some detail on some of the pathways that are creating particular drama. We have reinforced the cancer-tracking process to make sure that the pathways are in appropriate chunks so we are not always chasing our tails.

Jonathan Best: Jane Grant is right. Some of the big-volume cancer modalities are bringing us the most challenge—lung, breast, colorectal and upper gastrointestinal cancers. There are a number of reasons for that. There is a workforce issue in some areas. We have tried to recruit to our consultant radiologist cohort in particular; we have had a number of vacancies there for some time. That is a real difficulty for the diagnostic part of the cancer journey.

I am delighted that nine new consultants are starting over the summer. Many of those who have been trainees with us are staying with us and have achieved their first consultant role, which is good news. We have just appointed a new breast

radiologist in the Clyde area, which is one of our most challenging areas. We are working hard to recruit and retain people to address the workforce issue.

As Jane Grant suggested, getting the volume of patients into that first out-patient appointment slot within 14 days is a key target that we are working on. At the other end of the spectrum, some of the cancer pathways have become very complicated, with multiple stages. For example, in cases of colorectal cancer, we used to see patients going through two or three stages with diagnosis. Now, we have much better diagnostic and imaging equipment, such as positron emission tomography-computerised tomography—PET-CT—and more detailed testing, which means that there are multiple stages. That sometimes makes achieving the 62-day target harder. However, the committee will be aware of the national consensus conference at the beginning of May, which involved all the cancer centres. Following that, all the pathways have become the subject of a review. The best practice from each board will be taken through the three regional cancer networks and the review will look at how to improve cancer pathways to get back to achieving a 95 per cent rate for the 62-day target.

Emma Harper: Your submission mentions that urology is a challenge. Is that because of vacancies?

Jonathan Best: We have had a number of challenges in urology, including vacancies. We have been recruiting to the new robotic prostatectomy service in Glasgow and we finally have our four consultants in place, which is a step forward. However, some subspecialties in urology, such as reconstruction, are very hard to recruit to. We are out scanning and trying to persuade folks to work with us in Scotland, because that will be a key area for achieving the targets.

Emma Harper: I know that our ageing population with multiple comorbidities and our increasing population will be a challenge. Multiple disciplines—breast, lung and urology—are being squeezed at one end, but your pathway processes will also be affected by the increasing and ageing population.

Jane Grant: That is why we need constantly to review our capacity and ensure that, for instance, the slots and the clinic templates reflect current demand. We look at that all the time to ensure that we can deal with the demand profile. We must be fleet of foot in responding to changes in the demand profile.

As Jonathan Best said, the key is to keep waiting times down for out-patients who are in the urgent category at the front of the pathway and to ensure that diagnostic capacity is tailored to those patients and that we have a proper tracking mechanism. We need to flex capacity and we do so when we have to.

John Brown: To pick up on Emma Harper's point about the change in demand in the system, I ask Jennifer Armstrong to talk a little about the way forward for cancer services, the cancer pathway and the changes that we are looking to make, and the regional work.

Dr Jennifer Armstrong (NHS Greater Glasgow and Clyde): A lot of detailed work goes into cancer planning. We work closely with the Information Services Division on looking at all the tumour groups; we have done that as part of our moving forward together programme. We can project fairly accurately to about 2025 to 2030, so we know how many cancers to expect.

For eight tumour groups, we look at best practice worldwide, at new treatments that are coming on board and at new radiotherapy techniques. We employ a cross-system approach, which involves people from GPs to oncologists. They look at what is happening in breast cancer treatment, for example. We then do radiotherapy planning, which is done for the whole of Scotland. That involves questions such as the number of big linear accelerator machines, which are part of a capital planning project with the Scottish Government.

We ask what is happening. We ask, for example, whether we can devolve chemotherapy delivery to more local units, which depends on whether the chemotherapy is intravenous or oral. We know that an increase of about 40 per cent will be required in that service between now and about 2023. Under a whole-system approach, we have a regional plan for chemotherapy and for developing the cancer units, and we are looking at the cancer centre.

At the other end, in the public health debate, it is interesting that people can do a lot of things to lower their risk of developing cancer. That information became available in about 2008-09—for example, we now know that obesity is a driver for many cancers.

The approach must be across the system. We are thinking about smoking rates going down, for example, and what will happen because of that. As part of the moving forward together programme, we have projected the increases. We are looking at redesigning delivery, but a step change in capacity will also be required as the numbers begin to rise.

Emma Harper: Is there an opportunity to deliver radiotherapy more locally, or will it be delivered in core central belt centres? It was interesting to hear about telehealth, which might work for orthopaedic surgeons but not for chemotherapy, which has to

be delivered face to face because of the requirement for intravenous management.

Jennifer Armstrong: There has been an interesting debate about radiotherapy. I used to work in the Scottish Government on the better cancer care plan, and we have a satellite centre in Lanarkshire with three linear accelerators, as well as the 12 at the Beatson. The thing about radiotherapy is that we have to be extremely precise in how we do it and there are some five different stages of checking, including checking that we have got the fields right and checking the patient. It is a complex treatment to do. There is a balance to be struck and we need to ensure that we do not devolve it too much. The quality control has to be absolutely right.

At the Beatson, we have about 700 treatments a day, and every single one is carefully planned by a consultant and carefully delivered. However, we have seen a big volume of cancer around the Lanarkshire area, and the Lanarkshire satellite is working well. It is delivered by staff who were trained at and are part of the bigger system at the Beatson, but it is delivering more local radiotherapy. That is part of the debate that we are having at the moment.

If you watched the TV programme about the Beatson, you will have seen that a lot of the new machines that we brought in are delivering more targeted radiotherapy to prevent the side effects. You will have seen that with the prostate cancer treatment.

A lot of debate is going on as part of our moving forward together programme on keeping the quality control, looking at population growth and then looking at our service model and delivery, and that is what we are doing.

The Convener: One of the other requirements in the most recent accountability review was to keep the Government informed of significant improvement in local health improvement activity. David Stewart has some questions on that.

David Stewart (Highlands and Islands) (Lab): I am interested in public health and, through the work of the Scottish Parliament information centre, I have looked carefully at male life expectancy in Glasgow, which has been well documented. In that regard, you are still lagging behind the other major Scottish cities, albeit that the rate of increase in life expectancy is similar so it is, in effect, an historical lag. Is that your top public health objective? I ask Jane Grant to run through the issues on that.

Jane Grant: We pay a huge amount of attention to health improvement, life expectancy and trying to close the gap, and we have a lot of on-going programmes. David Williams and maybe Jennifer Armstrong can pick up on some of the detail on those programmes, but we are working hard on smoking cessation and on tackling obesity to try to improve patients' lives overall. It is not just about health; the issues are much wider than that. We have a lot of work going on both within the board and within partnerships, and that is co-ordinated through some of the board's activities.

David Williams: We are focusing in particular on smoking cessation and alcohol brief interventions, although not exclusively on those. The health and social care partnerships across the board area are taking an important role in collaboration with not just the health board but councils, and we have activities and active participation in communities, so the community planning partnership arrangements are important in that regard. There are also elements about good physical and mental health in all that work.

On the smoking cessation programmes, the quarter 2 figures for 2017-18 suggest that we are marginally below the target for the number of quits at 12 weeks, but we are a good bit further on from the same period last year, and we are encouraged by that. It is down to improved performance in pharmacy and community services, which are working together on intervention programmes. There is joint working on smoke-free pharmacy services. We have done some particularly good work in Possil on the connectivity between pharmacy and community services, and we want to roll that out to other poorer and deprived areas of the city.

Outside that, we have, for example, an incentivisation scheme in East Dunbartonshire, with a partnership between the HSCP and the Strathkelvin Credit Union, which is about a financial reward for people in the 15 per cent most deprived areas. A range of actions are being taken to address that particular issue.

11:00

David Stewart: A very interesting study was carried out for the Glasgow Centre for Population Health—you are probably well acquainted with it. I found it fascinating that cities with the same socioeconomic difficulties were being compared and contrasted. We cannot be naive about this; there is clearly a major factor in your patch that causes excess mortality.

The study compared Glasgow with Liverpool and Manchester, and it argued that the excess mortality in Glasgow could not be put down to any social index in Glasgow. I know that there is some on-going research on that. Have you contributed to that study? What is your observation on the study? The points about social deprivation are really quite interesting.

John Brown: David Williams and I both sit on the board of the Glasgow Centre for Population Health—indeed, I chair that board.

David Stewart: I suspected that you might.

John Brown: You have made a valid point about the issue in Glasgow being historical and about the work that the Glasgow Centre for Population Health did last year to bring together its 15 years' worth of research into why Glasgow does not compare favourably with other cities, although you would think that it would. As I am sure you know, having read the report, much of that is down to decisions that were made a number of years ago around planning and the distribution of the population in the west of Scotland when the new towns were being set up, as well as decisions on where investments were made in Glasgow, which perhaps differed from how the local authorities in Liverpool or Manchester made their investments.

I suppose that we are paying the price for earlier decisions, but I want to reassure you that public health is a top priority for our board. I have touched on the fact that, when we considered the triple aims and made them quadruple aims, we moved public health and better health to the top of the list. As a board, we are driving that.

This year, we have introduced a public health sub-committee of the board for the first time. That sub-committee allows the non-executives to help to set the direction, working with the public health director and her team. It also helps us to hold to account the colleagues in the HSCPs who deliver many public health initiatives and the colleagues in the board who do that.

On the public health sub-committee, we now have membership from the Scottish Government, so I think that we are being quite influential in setting the agenda for public health across Scotland. The chief executive of the Glasgow Centre for Population Health is also a member. As you know, the Glasgow Centre for Population Health pulls together Glasgow City Council, the University of Glasgow and the health board, so we have representatives of academia, the local authority and the health board all there together.

We have also started to work with Glasgow Life, because public health is about more than simply smoking, alcohol, drugs and obesity. Lifestyle is also a factor, and Glasgow Life gives us support in that respect. We have been working closely with Clyde Gateway and we are interested in what it has done since the Commonwealth games in the east end of Glasgow, where regeneration has improved housing and the employment rate has gone up, but health has not yet caught up. We are trying to get ahead of the game so that we can understand more about that.

David Stewart: You mentioned public health initiatives that have made a big difference. Historically, the smoke-free zones were important, and the smoking ban has obviously made a huge difference. Last year, we did quite a lot of work on low-emission zones and we took some evidence from Glasgow on that at another committee. I am conscious that health inequality really hits Glasgow. It tends to be the poor and disadvantaged, the ill and the elderly who are hit by nitrogen oxide and particulate matter. Glasgow will be leading on the pilot, so how important will that be in changing public health outcomes? Could we see the life expectancy graph go up to meet the Scottish average once the low-emission zone has been running for a few years?

John Brown: We certainly expect the life expectancy graph to go up as each generation comes along and is living in a healthier environment because of smoke-free zones and low-emission zones, and also because of education around better lifestyles.

David Williams may wish to add something from the perspective of the HSCP.

David Williams: John Brown commented on our relationship with the Glasgow Centre for Population Health. We had a development session for the Glasgow city integration joint board towards the end of last month, and the entirety of that session was devoted to public health. The IJB is committed to making public health its top priority.

Much of the learning that the Glasgow Centre for Population Health has been working on is now very much at the forefront for the IJB members and the officers have been tasked with coming up with ways of improving life expectancy, particularly for men. The low-emission zones agenda will be significant in that respect, but it will be one part of a jigsaw—there will be a panoply of interventions to address the issue. It will not of itself necessarily get us to the Scottish average, but it will play an important part.

Brian Whittle (South Scotland) (Con): I would like to explore that further. I am particularly interested in the preventative health agenda. If we look behind the life expectancy averages for Glasgow, we find that within quite a tight community there is a huge disparity of about 16 or 17 years. We have heard how we are tackling the issues of people who have already fallen into ill health through smoking, obesity, musculoskeletal disorders or type 2 diabetes. What work are you doing, or should you be doing, to prevent people from getting into that situation?

We recognise that it is not just health board initiatives that are required here. Obviously, education and planning are relevant, too. What

work are you doing to prevent people from following those patterns?

Jane Grant: I will ask Jennifer Armstrong to pick up on the first part of that question, and then David Williams.

Jennifer Armstrong: I know that the committee has taken evidence about adverse childhood events. Quite a bit of work has been done on that in Glasgow and Clyde. If people have a score of four out of 10 or above for adverse childhood events, we know that their chance of dying by violence or suicide, or just about everything, goes up dramatically. There is a real focus on trying to ensure that children have a better experience in Glasgow, because those patterns are set through generations and we see them playing out through generations.

The Manchester study, which I think that you alluded to, showed that there was a lot of excess mortality around violence and drug addiction and that it was not uniform across the patch. There has been quite a lot of success with the multi-agency work on trying to reduce violence and gangs, but ensuring that we provide as good an environment as possible in which to bring up children is key to that work.

The next step is to look at key causes. The big challenge for society and the NHS is how to keep people healthy. I do not like the word "co-produce", but we need to ask how we can encourage people to take exercise, and we have done a lot to promote exercise. It will be interesting to see the impact of the new legislation on alcohol minimum pricing, because we are trying to shift the alcohol curve over to the left, so that everyone is drinking less at local level, particularly in deprived areas where strong alcohol is consumed at a high unit count and at low cost. We hope that the legislation will help us to reduce consumption there.

There is a range of different initiatives, which are targeted at different age groups. Much of the work that we are doing on the moving forward together programme has involved asking the community, and it has said clearly that we need to give people information so that they can manage their own conditions. Once someone has an early chronic condition, we need to provide a lot more information, so that people can manage their conditions for themselves. We are seeing that coming to the fore more.

You have done a lot of work about aspects of children's health. We might not see the results of that for 20 years, but we need to focus on those areas in particular.

David Williams: The community planning partnership is key to what we are doing in the city. The two priority themes for the partnership in relation to the local outcomes improvement plan are early years and transport, and it is recognised that there is a connection between the two. The health board and the health and social care partnership are core members and partners in the community planning partnership arrangements.

The council has recently published a report from its health and inequality commission that is looking into mental wellbeing in the city. It looks at early intervention and the prevention agenda—trying to prevent people from feeling unwell mentally, which can spiral into other more concerning aspects of behaviour and presentation. The city government is committed to taking forward a connected whole-system approach that looks at what we can do more preventatively.

I will finish with what Jennifer Armstrong has been indicating about the centrality of the getting it right for every child agenda in the early years, which applies across not just the city but the whole health board area. There are clear connections with the education of children, which we need to make. It is not just a health board issue, as you quite rightly said.

Brian Whittle: As a brief follow-on, I think that Mr Brown alluded to the role that planning plays. For example, we know that in the lower-income percentiles there is a higher propensity for fast food and alcohol outlets. Has any work been done on taking a long-term look at planning and how that can change?

John Brown: That is where the connection in the Glasgow Centre for Population Health is very helpful, because that brings together the council, the health board and the academic research that provides that evidence. It is more of an issue for the council, I would say, in making its decisions about where to allow those outlets to flourish.

Brian Whittle: Do you have any input to that?

John Brown: Yes, we do.

Sandra White: Most of my questions have been covered. I am glad that you recognise the fact that, for many years, planning has thrown people out to housing schemes where there is absolutely nothing. That creates a sense of loneliness and deprivation.

I am pleased that you mentioned education, but how much work do you actually do in schools? Obviously, I live in Glasgow and represent the city, and I want to be able to live longer, as does everybody else; I want people to have a better quality of life. However, in the outlying areas there seems to be a lack of aspiration—that seems to affect people so that the positivity is not there. Does the health board do any work in schools—primary and secondary—on improving the children's health?

As has been said, the issue is not just health; it is much more holistic. We heard evidence on that from the cabinet secretary a couple of weeks ago, when she said that all portfolios in the Government must work together to improve health in Scotland. What input does the health board or others have in schools? I am not necessarily asking whether you go into schools yourselves, but do the IJBs or others have any input—do they speak to teachers and that type of thing?

David Williams: My colleague Maureen McKenna, the director of education services in Glasgow City Council, is very clear about the importance of children's wellbeing and the importance of our health improvement colleagues in the partnership supporting schools to make sure that their programme of activity and engagement with children is as healthy and active as it can be. We have connections and engagement with schools, not only within the city but across the partnerships in the board area.

The Convener: We have time to address issues of finance and process, starting with Ivan McKee.

Ivan McKee (Glasgow Provan) (SNP): Good morning, panel, and welcome to the Health and Sport Committee. I want to touch on a couple of areas—first, the financial aspects, and then some of the efficiencies and process improvements that sit behind how you are driving improvements in Glasgow. Let us start at the beginning. What is the health board's total budget for this year and how does that compare with last year's budget?

John Brown: Mark White will give you the underlying detail, but I will start by saying that our budget is £3.1-plus billion a year, which is made up of provision for a range of services. It increases, year on year; Mark will give you more detail on all that.

11:15

Mark White (NHS Greater Glasgow and Clyde): The income that we have received for 2018-19 is £31 million more than last year. The largest part of that is the 1.5 per cent uplift to our core income from the Scottish Government.

As we have discussed, we also have a number of service level agreements with neighbouring boards for services that we provide. Those agreements have an increase for inflation built in, which gives us an extra £5 million to £6 million. We have other smaller sources of income, such as the national new medicines fund, which provides a couple of million pounds. That sums up where the additionality comes from.

Countering that, we have a range of pressures that we have to manage. This year, they amount to just under £100 million, a large part of which is the £41 million or £42 million payroll pressure as a result of people moving up pay scales, plus the commitment in the Scottish budget to award a pay increase.

As always, we have other pressures that we have to manage; prescribing, for example, is the biggest pressure outside payroll and amounts to £23 million or £24 million for acute services alone from increases in both prices and volume. On top of that, we have the usual increases for inflation that would be expected in supplies and sundries, which amount to about £10 million to £12 million.

Against that level of income, we have to balance that level of financial pressure from increases in all those areas each year.

Ivan McKee: Is the £31 million additional to last year in cash terms?

Mark White: Yes.

Ivan McKee: That sets the scene. John Brown mentioned earlier that the board had achieved £60 million-worth of savings in "the previous year". I assume that that is 2017-18.

John Brown: Yes.

Ivan McKee: Did the board exit that year with a financial balance?

John Brown: Yes.

Ivan McKee: Moving into 2018-19, what is the equivalent figure for savings that the board needs to achieve? You mentioned £40 million.

Mark White: It is slightly more than that.

As a caveat on the 2017-18 position, I have still to go through the annual audit process. Internally, we are saying that we were in financial balance, but we have to have that position approved by Audit Scotland. I do not envisage any problem, but we have to go through the process.

This year, for the board in general, including IJBs, the figure would be about £92 million. For the board alone, without IJBs, it would be about £85 million. That is the savings challenge that we have in-year.

Ivan McKee: It is clear that the board has a track record of delivering that scale of savings. NHS Greater Glasgow and Clyde is a large and complex organisation that has a lot of different things going on. That makes it challenging, but it also means that there are probably many opportunities to dig away at and find. The board has demonstrated the ability to do that.

I want to dig down to the next level and ask about the process improvement that allows the board to identify opportunities and deliver savings. Does the moving forward together programme

encompass all that, or does it have a different focus?

Areas such as service redesign will potentially produce big, chunky savings as they are worked through, but there are also hundreds and thousands of small actions up and down the organisation that will drive small savings that all add up cumulatively. I am more interested in the small savings. By what process does the board identify the hundreds and thousands of small things up and down wards that all add up to a number? What is the process whereby a nurse or a doctor on the front line can say, "If we did this, it would be cheaper—or more efficient—than that" and that will feed in and be considered, and acted on, by management?

John Brown: Before we move on to that point, I want to be clear that the figure that Mark White quoted is the financial challenge. Not all of that is met by efficiency savings; some will be met by additional funding in-year. As the year goes on, we get additional funding for the winter, to target waiting times initiatives and so on.

Ivan McKee: Is that the difference between the £80-odd million and the £40-odd million?

John Brown: Yes. I quoted the efficiency savings figure that we are looking for. Mark White quoted the financial challenge. It is important that the difference is understood.

Ivan McKee: That is fine. That is clear.

John Brown: To meet the financial challenge, we have to do a number of things. We have to look at what might come from national initiatives, what might come from regional initiatives and—as Mr McKee rightly said—what the board can do itself.

At one end, we have a bottom-up staff suggestion scheme—it is called small change matters—which does not give us a lot in cash terms but helps us to encourage an empowerment culture to involve the staff. However, the scheme will deliver because a lot of small change matters. Within the directorates, there are the normal efficiency plans and there is the cross-cutting, end-to-end system. Those are the different tiers and levels. Mark White will talk you through some of them.

Mark White: We have tried over the past 18 months to launch and reinvigorate the small change matters scheme, because the front line is where the money is spent and that is where we have to manage behaviours and financial control. We have really worked our communications team to get a lot of information out to staff. By launching an electronic form on an internal staff net, we have given every member of staff the opportunity to bring forward their ideas. We then review and consider those ideas and liaise with individual staff members to turn the idea into a savings programme, with their help. We are ramping that up and trying to get the maximum from ideas from individual staff members and self-formed groups of staff. We are therefore doing a lot through a process that inherently involves staff.

The second level of savings, to which the chairman alluded, involves the devolved budget process that we have across the board. We give out a savings target to every director and general manager who has their own budget line, which can vary from 1 to 2 per cent across the organisation. That figure is expected by those directors and general managers, and they will come up with a range of schemes within the figure that they will subsequently deliver.

There is one thing that has always been within the board but which we have tried to change a bit this year. We are trying to manage a lot more centrally to get some organisation-wide initiatives, focusing much more on efficiency and getting more for the same by working around our processes and internal ways of working to bring change across the organisation. We deliver our acute services from five or six sites and there is a lot of variability across working practices and performance, so we are trying to get the best from those and roll it out across the organisation. By establishing a central programme management office this year in the board headquarters, we are looking to support and bring new ideas to each member of staff and to get more from that process.

The top level of savings, to which Ivan McKee alluded, is around transformational change, which is much more medium to longer term. We envision small savings through that this year, but there has been much more focus on that in preceding years. That has happened predominantly around regional working; we have only touched on that, but it takes up a lot of our time and effort. There is also the moving forward together programme, which is internal in Glasgow and is looking at service redesign and delivering in different ways; obviously, there is a big focus on shifting the balance of care.

Those are the different layers that we are adopting this year. There is a slight change to what has been done before, but we are building on the good progress and delivery that we have had in the past.

Ivan McKee: That is clear. Thank you.

The Convener: The projection that was published the other day for December 2017 suggested that NHS Greater Glasgow and Clyde faces an overspend for the year just finished of £20 million. However, you are telling us today that

that has not transpired. Was that simply an accounting matter, or was it a substantial change in the last quarter of the financial year?

Mark White: It was a combination of a number of things. When we set out the financial plan in June last year, we had an £18.5 million projected gap and that is what we have been operating with throughout the year. When that became evident, we took a number of measures to try to bring it under control. We put in place a lot of processes around financial controls—financial grip, as we call it—and had far greater scrutiny and monitoring around a lot of our budgetary and non-discretion spend. We did that, for example, around our premium agency nursing, which was a big cost for us. However, we have halved that in-year through better management, better interaction with our staff and better monitoring procedures.

We have also been very big on our supplies and sundries spend. Again, we have managed to take £5 million out of that, with much of that coming in the latter quarter of the financial year by the time that the schemes and processes were in place. A range of financial controls and financial grip happened in the latter part of the financial year.

Winter is obviously a huge area of pressure for us. We were projecting significant financial pressure around winter; some of that was about being prudent and some of it was around the pressures that we have experienced in the past. We put a lot of time, effort and detailed planning into winter this year and we were able to deliver winter within the financial envelope that we had set out. Again, that comes through in the last quarter.

As I mentioned, a range of saving schemes were identified at the start of the year. Those take a lot of time and a lot of effort from staff to deliver and a number of them crystallised in the last quarter, which again helped to impact on that number.

We were predicting an overspend around the £18 million to £20 million mark all through the year and then, as we came out of the back of Christmas and the back of winter, with a bit of clarity and a bit of rebasing of some of our assessments, we were able to bring down that overspend to around £8 million by the end of January going into February. We then got back down to financial balance at the end of the year.

Miles Briggs (Lothian) (Con): I want to pick up on that point because the most recent audit of the board's accounts pointed towards you carrying forward unachieved savings of £29.6 million. Where have you looked to identify future savings?

Mark White: The £29.6 million is our underlying recurring deficit coming into 2017-18, and that is an area that we are continuing to try to look at.

We have covered a range of different things in year. An example of one of our big successes in 2017-18 is pharmacy savings through using biosimilar drugs. We have a dedicated process of horizon scanning and we try to identify expensive branded drugs that are coming off patent or coming to the end of purchasing deals. We put a rigorous process in place to get all our clinicians and pharmacists to prescribe those biosimilar drugs rather than the more expensive ones. In year, for 2017-18, that saved us upwards of £12 million in the acute division alone. That is a big area for us.

I touched on nursing. Another big area of spend for us has been on medical locums, and in 2017-18 we have really focused on that. We have managed to reduce our spend in that area by £2 million just by adopting a far more rigorous and detailed process to deliver those services differently. The big areas of prescribing and staff spend are the areas that we have really looked at in 2017-18 to try to drive the level of savings that we need.

Miles Briggs: John Brown mentioned A and E visits in his opening remarks, and he said that the board experiences half a million A and E visits per year from a population of 1.1 million people. A and E is often a good test of how people are using health services. What work are you doing around that to get people to go to the appropriate professionals? What does that figure say about general practice across the health board area, especially given the challenges that were outlined for deep-end GPs?

John Brown: It comes back to the point that was made about public health. The Glasgow and Clyde area has always been an outlier when it comes to use of the NHS; there has always been significantly higher use of the NHS in Glasgow across all the population groups—it is not particular to any one group. In A and E, we have consistently been 11 per cent above the norm. As to what we are doing about it, I will hand over to Jane Grant.

Jane Grant: I will give you the overarching board position. As you are probably aware, we had a root-and-branch review of some of the emergency work that caused us a challenge the year before last. This year, we have set up an unscheduled care steering group from across the board, which includes a number of the chief officers from partnerships and a number of the directors from the acute sector as well as corporate colleagues, to make sure that we are looking at all the drivers of that activity.

One of the board's objectives is to reduce that demand and reprofile it in a different way. We are trying to make sure that we have proper anticipatory care plans in place and that we are

clear with GPs about what the services are. We are trying to look at patient education to make sure that patients are aware of the range of alternatives. We are looking at whether there are initiatives at the front door so that, when patients appear there, we look at other appropriate pathways for them, rather than having them go through the assessment unit or admissions unit.

We are also looking to promote our minor injuries units in those areas where we can treat patients there, and we are looking at other alternative areas where appropriate, so we have a range of things going on. David Williams or Jonathan Best might want to pick up on some of the other things—there is a lot of activity in the area.

11:30

Jonathan Best: We saw a 1.7 per cent increase in attendances over the year ending in March this year. It is important that, as well as having the unscheduled care group at board level, we now have three integrated unscheduled care groups based around the three main sites—Paisley's Royal Alexandra hospital, the Queen Elizabeth university hospital and the Glasgow royal infirmary. Through David Williams's team and all the IJBs, those are now joint integrated groups.

We are trying to get as integrated an approach as possible to what we can do when people come to our front door. We have services such as social work at the front door. A good example is the Queen Elizabeth, where we have a frailty unit with 10 assigned beds. Instead of going through a lengthy process, patients can go to that unit, which has a dedicated team that tries to turn them round and keep them as mobile as possible at home or in another location. There is a range of services.

We are also working with the Scottish Ambulance Service. As you know, its people are often the first ones to get the call or get to the scene, and we are working with them on appropriate places to go. Jane Grant mentioned our minor injuries unit. We are trying to get our ambulance colleagues to work with us and patients to suggest that, instead of turning up to a busy emergency department, patients go to a minor injuries unit where they will be treated quickly, turned round and sent back out.

The other question for us is how we manage the older, frailer patients who come to EDs. It is important that we work with our social work and IJB colleagues to ensure that people go to the appropriate place. Over the winter, we ran extensive media campaigns—local radio campaigns, adverts and leaflets drops—to try to point people to the right place to get the most appropriate treatment. We will continue to try to improve in that regard.

David Stewart: From speaking to community pharmacists, my take on it is that they feel that they are an underused resource. The "three before GP" campaign is extremely good. I am sure you are already doing this, but can you link in with that service? Other boards have considered that.

I read this week about English health boards targeting people who are persistent users of A and E—not because of normal medical issues, but people who go to A and E hundreds of times. The boards have managed to reduce the figures dramatically. Have you examined that? I think that was in *The Economist* this week. I do not know whether Dr Armstrong is able to speak about it.

Jennifer Armstrong: The Scottish Government published a pharmacy strategy a few years ago called "Prescription for Excellence: A Vision and Action Plan for the Right Pharmaceutical Care through Integrated Partnerships and Innovation". We have done quite a bit of work with community pharmacists on minor ailments services, for example. One of the big things that we are considering now is what access we give them to the clinical portal, which is the patient record. We need the patient's permission to do that, but it is also about the drugs that they are being prescribed.

I think that community pharmacy will develop in much more meaningful and constructive ways. That applies not only to access to patient records but, given that community pharmacists already provide a lot of minor ailment services, to their being the first port of call. We have done quite a lot of work with optometrists, for example, and we are changing the first port of call for patients who have an eye condition to be an optometrist. Over the next few months, you will see a lot coming out about people working to the top of their licences, about shifting work away from GPs and about ensuring that patients access the level that is appropriate to their needs rather than pitching up to A and E.

There is some interesting work that we might do on frequent attenders in the north of the city. Often, they are patients with mental health problems who are in crisis. The question is what services we need to put around those patients to prevent them from using A and E. We know the list of those patients, and quite a bit of work is going on between A and E and GPs to determine how we can put more preventative measures in place to stop them attending A and E. That work will play out over the coming months.

We had 32 clinical groups looking at the moving forward together programme. We have engaged about 600 clinicians and we had cross-system

groups. We asked them what they currently do in hospitals that they could do in the community, what they currently do in the community that they could do at home and what they currently do at home that they could do virtually. We are seeing a big programme shift away from A and E.

We have a stakeholders reference group, which has all the charities and patients representatives on it, and we have been playing out all the developments with that group over the past few months. The group's members all said clearly to us that, if we make the big transformation in care that we would like to make, which we will describe, we will need to educate patients about where they have to go, because that can be confusing for them.

Because A and E is a big brand that people see, that is the easiest place to go. *The BMJ* this weekend contained an interesting article that said that patients are a bit unsure about seeing a pharmacist. We need to set out our stall, take patients with us, get their engagement and be clear that services other than A and E are appropriate to their needs. Too many people turn up at A and E. The four-hour target should be preserved for acutely unwell patients who need to be seen quickly, and that is a big challenge not just for NHS Greater Glasgow and Clyde but for other boards.

The Convener: Emma Harper has a brief point of information.

Emma Harper: Jennifer Armstrong mentioned virtual aspects. Work is taking place across Scotland to ensure that people can self-monitor conditions such as chronic obstructive pulmonary disease, so that they do not need to be admitted to hospital. We have not even scratched the surface of the potential savings that telehealth could produce.

Sandra White: I will ask about integration joint boards, but before I do that, I think it would be remiss of me not to talk about minor injuries units, as they have been mentioned. I am sure that a lot of work goes on—reconfiguration of care has been mentioned, as has speaking to people and being transparent. There is an open question, which I have written letters about, in relation to the closure of Yorkhill's minor injuries unit, where the decision certainly was not transparent to the people in my constituency. Will patients now go to Gartnavel or elsewhere?

I am sure that the witnesses have input to the integration joint boards. I say to Mr Williams that you have an absolutely massive amount of work to do. Jennifer Armstrong mentioned the moving forward together programme and engaging with the public. What input do the joint boards and the six partnerships have to decisions such as the one about Yorkhill's minor injuries unit? Given all the work that is going on, and given that one size does not fit all, how difficult is it in practice to deal with six separate IJBs? Can progress be made in that regard?

John Brown: You have raised three points. Your first point was about the communication of the original closure of the minor injuries unit that was based at Yorkhill. I apologise for the poor communications about that, which we did not get right. I have previously apologised to you and your constituents for that, as you first raised the issue with me. We are conscious that we have made mistakes, which have damaged public confidence in us, and we are looking at how we can be better. Jennifer Armstrong mentioned the engagement group that we have set up for our work on designing the new system, and it involves patients, patient representatives, charities and other stakeholder groups. We want to do more such work and to get better at it. We are learning from our mistakes.

Sandra White asked where people who live in the relevant part of Glasgow should now go for minor injuries treatment. Jane Grant will talk about that, and I am sure that David Williams can give insight into how widely the health and social care partnerships and the IJBs that govern them are involved in the end-to-end system and the provision of the system.

Jane Grant: As Sandra White knows, the Yorkhill minor injuries unit was opened for the winter, and we extended its opening until 20 April to allow the Easter period to go by. In that time, about 20 patients a day went through the unit. At weekends, the number was much lower—it was perhaps fewer than 10. A relatively small number of patients went to the unit, although we recognise that access is important. Patients who would have used the unit are now principally going to the Queen Elizabeth.

As part of the moving forward together programme, we are looking at the profile of emergency care and our elective pathways, and minor injuries unit patients will be part of that process. As Jennifer Armstrong said, we are considering whether all the patients who come to a minor injuries unit need to do so or whether they would more appropriately be moved to a different place. We are looking at how many people need to come to a minor injuries unit and why. That detailed work is going on under the moving forward together banner to ensure that we have the right services for the right people.

Moving forward together gives us the opportunity to design services for the current population need. Quite a lot of services have grown up over a large number of years—that is the case in all health boards—so this is our

opportunity to consider what patients require and do things in a new way, with new models, rather than just doing more and more in the old ways.

There will be a change for some people. As Jennifer Armstrong and other colleagues have said, we need to take the population with us. A lot of work is going on, but the minor injuries unit and minor injuries patients will be reviewed as part of the process.

David Williams: There is no doubt that integration is complex, particularly when we are talking about multipartnership areas such as Greater Glasgow and Clyde, which covers six partnerships, and their facilities. The board needs to strike a balance between recognising and respecting the responsibilities and duties of the integration joint board and ensuring that patient care is consistent across Greater Glasgow and Clyde—and beyond, because many patients come into Greater Glasgow and Clyde from outwith the board area, as the committee has heard.

There is a need for collaboration and joined-up working. The chief officers in Greater Glasgow and Clyde meet formally on a monthly basis to ensure that we are working together. There is a legislative requirement on us to co-operate with each other in a multipartnership board area to ensure, for example, that Dr Armstrong's responsibilities in relation to clinical governance leadership are not compromised because one IJB decides to go down one route and another IJB takes a different decision.

Beyond that, I think that chief officers and health and social care partnerships are beginning to get engaged in the west regional planning agenda. There are 15 of us who are discussing how that is evolving. As I said, there is also the national health and social care chief officers network, which is developing an approach to learning and sharing and ensuring that there is a degree of consistency. By that, I do not mean that there is a uniform, one-size-fits-all approach. It is about recognising the differences within communities. That is the importance of locality planning in IJB areas.

If integration is to work, there is a need for a will to make it work across all partners in the arrangements—the IJBs, the councils and the health board—and a need for hard work. There is no question about that; that is the nature of partnership working. The committee has heard this morning that, in the key interfaces in relation to delayed discharge, unscheduled care and moving forward together, the partnerships in Greater Glasgow and Clyde are absolutely in the middle of all that work, jointly and together with the board and colleagues in the acute system. That does not mean that integration is straightforward. We are all learning about each other. However, we are committed to it and the will is there.

Sandra White: I am not asking to come to meetings, but when there are different areas involved, such as the Vale of Leven and Lanarkshire, and six IJBs are involved, how difficult is it to get consensus on priorities?

David Williams: Let me give the example of the five-year mental health strategy that we have collectively approved across the board areas and the process that we followed in delivering it. The strategy follows on from and is completely consistent with the Scottish Government's mental health strategy, and it is expected to deliver transformational change to how mental health services are delivered.

The hard work was around involving and engaging people, which is perhaps a different concept from the approach to the delivery of public services that was taken historically. It was about ensuring that the different people who are party to delivering on the five-year strategy, which is board wide, but must be delivered within the six partnerships because these are devolved responsibilities, worked together through monthly meetings and were party to the strategy's development so that, when it was presented for approval—initially at the Glasgow city IJB, because we host mental health responsibilities for the board area, although the other five IJBs and the board need to be party to that—a consensus was achieved. We have to be confident that people will sign up to such a strategy before it is actually presented.

The Convener: I thank all the witnesses for attending today. It has been a full session. The committee will now move into private session.

11:46

Meeting continued in private until 12:33.

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