OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 12 March 2019

Session 5

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CONTENTS

HEALTH AND SPORT COMMITTEE

8th Meeting 2019, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Nicky Berry (NHS Borders)
Jane Davidson (NHS Borders)
Bob Doris (Glasgow Maryhill and Springburn) (SNP) (Committee Substitute)
Carol Gillie (NHS Borders)
Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP)
Rob McCulloch-Graham (NHS Borders)
Dr Tim Patterson (NHS Borders)
John Raine (NHS Borders)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 12 March 2019

[The Convener opened the meeting at 10:00]

Subordinate Legislation

National Health Service (Optical Charges and Payments) (Scotland) Amendment Regulations 2019 (SSI 2019/50)

The Convener (Lewis Macdonald): Good morning and welcome to the Health and Sport Committee's eighth meeting in 2019. I ask everyone in the room please to ensure that their mobile phones are off or set to silent and not to use mobile devices for photography or recording of proceedings. We have received apologies from David Stewart and Sandra White. Bob Doris is attending as a substitute member, and I also welcome Christine Grahame.

Agenda item 1 is consideration of four instruments that are subject to negative procedure. The Delegated Powers and Law Reform Committee considered the first instrument, SSI 2019/50, at its meeting on 26 February, when it determined that it did not need to draw the Parliament's attention to the regulations on any grounds that are in its remit. As members have no comments, does the committee agree to make no recommendations on the regulations?

Members *indicated agreement.*

Food and Feed Safety and Hygiene (EU Exit) (Scotland) (Amendment) Regulations 2019 (SSI 2019/52)

The Convener: SSI 2019/52, SSI 2019/53 and SSI 2019/54 relate to the European Union (Withdrawal) Act 2018. Under the protocol that has been agreed between the Scottish Government and the Scottish Parliament, at our previous meeting we considered the categorisation and procedure for dealing with the instruments. Last week, we agreed that it was appropriate that each instrument had been laid under the negative procedure and given a categorisation of low significance.

I ask for comments on SSI 2019/52. The Delegated Powers and Law Reform Committee considered the regulations on 5 March and determined that it did not need to draw the Parliament's attention to them on any grounds that are in its remit. As there are no comments, does the committee agree to make no recommendations on the regulations?

Members *indicated agreement.*

Food Composition, Labelling and Standards (EU Exit) (Scotland) (Amendment) Regulations 2019 (SSI 2019/53)

The Convener: The Delegated Powers and Law Reform Committee considered the regulations at its meeting on 26 February and determined that it did not need to draw the Parliament's attention to them on any grounds that are in its remit. Do members have comments?

Emma Harper (South Scotland) (SNP): I understand that the regulations will make minor and technical amendments, but they made me think about the consideration of food labelling and standards in future, especially given that we read a paragraph about the origin of meat from certain countries. As we move forward with trade deals and negotiations, my concern is to ensure that our food products, standards and labelling requirements are not compromised.

The Convener: Absolutely—that reflects a point that you made when we first considered the regulations last week. It is fair to say that the amendments do not directly bear on the issues that you raise, but it would be entirely appropriate for us to write to the minister—while supporting the regulations, if that is the committee's view—to ask for a general update on the protection of Scottish beef and other designations. Would that meet your needs?

Emma Harper: Yes. My concern is about how labelling might change and about protecting our produce in any future trade negotiations.

The Convener: The clerks have noted that and we will ask for assurances from the Government. As there are no more comments, does the committee agree to make no recommendations on the regulations?

Members *indicated agreement.*

The Convener: That is fine—we will write an accompanying letter.

Nutrition (EU Exit) (Scotland) (Amendment) Regulations 2019 (SSI 2019/54)

The Convener: The Delegated Powers and Law Reform Committee considered the regulations at its meeting on 5 March and determined that it did not need to draw the Parliament's attention to them. As members have no comments, does the committee agree to make no recommendations on the regulations?

Members *indicated agreement.*

The Convener: That disposes of all the statutory instruments.

Scrutiny of NHS Boards (NHS Borders)

10:05

The Convener: Item 2 is an evidence session with NHS Borders, as part of our series of evidence sessions with territorial boards. I welcome to the committee John Raine, chairman; Jane Davidson, chief executive; Carol Gillie, director of finance; Nicky Berry, director of nursing; Rob McCulloch-Graham, chief officer for health and social care; and Dr Tim Patterson, joint director of public health.

I understand that Mr Raine will be coming to the end of his eight-year appointment at the end of this month and that Jane Davidson is retiring in April. I hope that you agree that this is an ideal opportunity to give us the benefit of your experience before you move on. An important area for this committee to consider is financial sustainability. With the benefit of your team and experience, I ask for your summary of the position regarding financial pressures and your view on the prospect of achieving financial sustainability.

John Raine (NHS Borders): Thank you, convener. As representatives of a comparatively small rural board, which is now in special measures, we hope that our experience can be helpful to the committee. It will, perhaps, offer you a different perspective.

We are in special measures because we do not have a balanced financial plan. We need additional funding and we applied for brokerage in the middle of last year. That meant that we were escalated to level 3 on the Government's escalation framework ladder. That was a bit of a shock to us, because NHS Borders has always been seen as a well-performing health board and, until the current financial year, we have always delivered on the budget.

We were taken even more by surprise to find that we were escalated to level 4 in November. We did not really understand why that should be until we received the letter that informed us that the seriousness of the financial situation that we faced was such that, coupled with the planned leadership changes, it justified the escalation to level 4. We assume that that referred to the fact that Jane Davidson had meanwhile announced her intention to retire and the well-known fact that I was coming to the end of my eight-year appointment term at the end of this month.

That all happened quite quickly and we have gone from being seen as—and, indeed, being—a board that has delivered well in terms of waiting times and services to patients, to one that has

keeled over in terms of managing the budget. One of the advantages of being escalated on the ladder is that we get help with turnaround. Yesterday, a turnaround team, which is funded by the Government, arrived to assist us. It will provide a consultancy report to enable us to get back on to a firmer financial basis.

There will be no quick fix; we are planning on a three to five-year turnaround. The extent of the overspend includes brokerage of just over £10 million on a budget of little more than £200 million, so it is a significant proportion. Pulling that back will not be easy. Brokerage has been written off in the current year, which is very helpful, but it means that we have an overheating of the economy of NHS Borders that we still have to rein back. We need to find ways of transforming services, because we are not going to deal with the problem just by getting a firmer grip and control over relatively small parts of the expenditure. It is pretty big stuff.

The financial settlement that we have been looking at for the financial year from next month gives us an even bigger gap to be bridged. There are two main reasons why we need brokerage. First, there is the inability to deliver sufficient efficiency savings of the magnitude required on a recurring basis. We have put a lot of effort into the efficiency programme, but much of it has resulted in one-off efficiencies. Indeed, Audit Scotland, as our external auditor last year, said that savings of an "unprecedented" magnitude are required.

Secondly, there is the low level of uplift that we have had as a board. Our net base allocation under the NHS Scotland resource allocation committee—NRAC—formula has provided for us increases in each of the past four years of 1.7 per cent, 1.6 per cent, 0.4 per cent and 1.5 per cent, respectively. That has led to some pretty tough challenges.

We are a rural board and the smallest mainland board in Scotland by population, but we have a large geographical area to provide services across and the highest percentage population of elderly people. All that contributes to additional costs. I would not want to be here pleading poverty, because I think that there is more that we can do to be more efficient. I am sure that we can deliver more, but it will take time and the turnaround support that we are now getting will help us.

The board has not been blind to the difficulties coming down the track. My view is that although we have owned the problem of not being able to manage within the budget, we have also owned the solution and I think that we have been trying to own that solution for too long, rather than elevating the conversation to Government level. I am not saying that there has not been a dialogue between our officials, and NHS Scotland and the health department, but I would accept some responsibility for not elevating the concerns that have been building up now for two or three years.

The Convener: Thank you.

You used the phrase "keeled over", which is quite strong language. It is clear from that initial answer that there was a degree of surprise on your part at the speed, scale and severity of the difficulty into which the board has come in the past two or three years. I will try to unpick some of what you said. Is it one of your points that it is more difficult for a smaller board to find efficiency savings than it is for a larger board?

John Raine: No. I would not want to say that. The question that is put to me very often is whether we are getting a fair crack of the whip under the NRAC formula. The answer is that we do not know. We know that rurality is taken into account, but we do not know whether it fully reflects the additional costs of a rural board with scattered small communities. We are funded at the level of NRAC parity and NRAC has existed now for 10 years. I have been a member of the technical advisory group on resource allocation—TAGRA—so I know that there have been reviews of elements of NRAC, primarily the additional costs facing island boards. There has also been a review of the morbidity and life circumstances element to see whether that is properly and fully reflected in the formula. I am leaving the service now, which is unfortunate, because I would like to stay, but I think that perhaps the time has come for a more fundamental look at the NRAC formula. I know that that would be a major task and that it would not deliver a larger quantum of resources, because it is about the allocation and sharing of resources.

The Convener: Correct me if I am wrong, but your board receives relatively low annual uplifts because it starts from a position of being above NRAC and has more as its base funding than NRAC provides.

10:15

John Raine: Yes.

You picked me up on my use of the expression "keeled over". That was, perhaps, rather an exaggerated position, because we have not keeled over in terms of services. At the end of this month, barring a devastating turn in the weather or other calamities, we are on course to announce that we will have no in-patients or out-patients waiting for more than 12 weeks and none waiting for more than six weeks for diagnostic tests, other than people who are waiting for magnetic resonance imaging scans.

I think that we will be the best in Scotland in terms of delivering services. We await that recognition; it is not in the bag, as it were, but I am hopeful that it will be achieved. We have always been consistent achievers of accident and emergency targets. Yesterday, we met the four-hour target for 100 per cent of patients and the day before the figure was 97 per cent. We have also been consistently good on cancer waiting times. It is a bit of an irony that we have not been able to manage the money effectively, but there are reasons for that.

The Convener: Those measures are clearly important from the patient's-eye view but, as you say, financial sustainability is essential if you are to continue to meet such targets. Given what you have described and the scale of the shortfall—the brokerage that is involved—you said that it will not be easy to achieve financial sustainability. Do you believe that it is possible?

John Raine: Yes, I do. I am reasonably confident that, over a time span of three to five years, we will be able to pull that back. However, much depends on future funding settlements.

The Convener: I know that some of the things that have been described as mechanisms to achieve future financial sustainability are already in process, for example the shift from hospital care to community-based care.

John Raine: A lot of attention is given to shifting the balance of care. I will call on colleagues to describe that. Shifting the resource that goes with it is a trickier matter. Perhaps the reason why I used the expression "keeled over" was that being on level 4 has a demoralising effect across the organisation. It concerns the board greatly.

Interestingly, my colleagues and I travelled on the Borders railway this morning and we sat with somebody we did not know, who listened to our conversation about coming here today. He said that he was a consultant at Borders general hospital and had been there for eight years, although none of us knew him. He also works elsewhere, in Lothian and other board areas, but he sang the praises of his working environment, the team spirit that exists and the conditions that he works in.

I asked him what the medical view was of the board being at level 4. He was not exactly dismissive, but he said that the medical staff just get on with the day job and accept that this kind of thing happens in cycles across the national health service. That made me think that that was really good experience and information for your committee to hear—how people on the front-line experience the real-life world of delivering services.

The Convener: We certainly try to do that. Finally, before I pass on to colleagues, can I ask about the Scottish Government recovery team that you mentioned. What is the nature of that engagement? You suggested that it is completely new and that there was no engagement until very recently. What engagement is there now and what effect do you think it will have?

John Raine: Can I bring in colleagues on that, convener? They can perhaps identify the individuals in the recovery team.

Carol Gillie (NHS Borders): The letter that we received from the director general in November said that there would be a tailored package to help NHS Borders to turn around its financial position. Since early December, we have had support from the Scottish Government's board recovery unit, which has provided us with expertise, external scrutiny and support to try to turn around our finances.

We have learned from the unit tried and tested methodologies and processes from other places, particularly from down south, where there has been success in financial turnaround. The unit has also reviewed our governance arrangements in relation to turnaround. It has helped us set up a project management office and everything that we want to take forward is going through that process. We have new documentation that we are following. The unit has helped us make sure that finance is a key agenda item in the organisation.

As John Raine referred to, the Scottish Government has also supported us to get some external individuals who have worked in other organisations just on turnaround—that is their area of expertise. They started with us yesterday, to provide that focus for us.

The package has been tailored to our needs and although it is early days, we have changed a lot in relation to how we work with the advice and support of the Scottish Government.

The Convener: Do I understand that to mean that staff have been seconded to NHS Borders from the Scottish Government?

Carol Gillie: I do not know whether "seconded" is the right word—they work with us. They are in NHS Borders a couple of days a week and we have some external support people who are non-NHS staff working with us.

Jane Davidson (NHS Borders): We have had people from the Scottish Government recovery unit involved since before Christmas and we are working in partnership with them as much as we can to get a level of confidence around the plan. The intent is to have a one-year plan to put before the board by the end of March and a plan for the next three to five years by August.

Just to be clear, it is a company that is providing turnaround support to us and that company started on Monday.

The Convener: What is the name of the company?

Jane Davidson: Bold Revolutions.

The Convener: And the Scottish Government appointed it to support you?

Jane Davidson: Yes, that is right.

The Convener: Thank you, that is useful to know.

Brian Whittle (South Scotland) (Con): On a point of clarity—you say that it is a three to five-year plan for turnaround. Does that mean that you will require brokerage for each of those years before you hit financial sustainability or will you require it across the piece?

John Raine: We will certainly require brokerage in the coming financial year. Beyond that, I will ask Carol Gillie to comment.

Carol Gillie: We have not bottomed out our three to five-year plan, but I can say with confidence that we require brokerage for the financial year 2019-20, and it is likely that we will require brokerage for a number of years after that, although I cannot pinpoint exactly how long.

The Convener: The Scottish Government has indicated that brokerage will be provided and, in effect, forgiven over the next year or two, but that will certainly not be the case for five years.

Carol Gillie: It has agreed to give us brokerage for the current financial year to enable us to deliver on our financial targets, which is helpful, and it has indicated that we do not need to repay the brokerage that we receive for this financial year.

We have flagged up to the Government that we will need brokerage for future years. We have not finalised exact amounts with it and it has not confirmed that it is comfortable with that, but we have flagged up that that will be an issue.

Jane Davidson: Just to confirm, by the end of March the first year's financial plan will allow that conversation to take place with the Scottish Government. The turnaround team from Bold Revolutions will help us to identify what is needed after that and, by August, we will be able to look to the next three to five years. At that point, we will be able to more or less nail down what brokerage might be required.

The Convener: Should it not be the other way around? Arguably, you should have the discussion with the Government first to find out what is possible and then talk about the turnaround.

Jane Davidson: I suppose that we are doing those things in parallel. We have been having those discussions and we have flagged up the fact that next year, certainly, and probably the following year, we will be looking to access brokerage. The Government is aware of that in its financial planning. However, we need to work out something a bit more concrete on the amounts that will be needed.

Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP): My first question is for John Raine. You said that it seemed as though everything was going along swimmingly and then you were surprised to find that you were in financial difficulty. Why was it a surprise? Did it come out of the blue?

My second question is for Carol Gillie. You said that the turnaround team came and said, "Make changes in the way you work." What were those changes?

John Raine: The surprise was more about being escalated up the ladder. I said that we were not blind to what was coming at us down the track. We have recognised that, over the past two or three years, it has been extremely difficult to make sustainable savings.

The fact that we were in some difficulty financially was not a surprise. Audit Scotland—our external auditor—last year flagged it up as being a real issue. However, we were surprised at the change in fortunes of NHS Borders. It has not been on the Government's radar as a difficult board. We have managed ourselves and done well. It was surprising to change from being seen as a good board to, in effect, being seen as a failing board. However, we are not a failing board. That is a message that we need to get across to our staff, and I did that in an address to our workforce conference on Friday. We are not failing; staff are working hard and we are delivering. The figures that I gave you in relation to access by the end of this month are good.

Carol Gillie: Christine Grahame asked about changes. The turnaround team has helped us to refocus on the financial agenda. In the health service, there are always lots of new initiatives. We are trying to prioritise the ones that will have a financial impact. That is not to say that we will not do other things, but it is a question of focusing on what will give us a financial benefit in the short term and maybe in the longer term. It is a case of refocusing the organisation.

Christine Grahame: Can you give me an example?

Carol Gillie: In Nicky Berry's area, there might be lots of initiatives that we can take to improve some of the care that we give, but they might not have a financial benefit. We are trying to find

opportunities that improve care and have a financial benefit. It might be a case of refocusing on things such as our prescribing costs and checking that we have the most cost-effective prescribing, which is good for the patient and saves money, rather than doing something that focuses only on the patient benefit. We are trying to focus the organisation on taking into account both the care agenda and the financial agenda.

Dr Tim Patterson (NHS Borders): To pick up on what Carol Gillie was saying, one of the key priorities will be prescribing. Prescribing costs have gone up significantly in recent years. We currently spend about £25 million in primary care prescribing and £10 million in secondary care prescribing. However, secondary care prescribing has gone up by 42 per cent in the past four years. There are many causes, which are outwith our control.

One of the big causes—particularly in relation to secondary care prescribing—has been the change in policy from the Scottish Medicines Consortium. Now, the Scottish Government's policy is to consider not just the evidence base whenever we introduce new drugs, but the views of patients and the public as well as clinical views. That has broadened out access for the new drugs. Although there has been an increase of 42 per cent in secondary care prescribing in the past four years, there has not been a commensurate increase in prescribing funding to fund that broadening of access.

We are looking at prescribing as one of our key priorities in order to get what we call financial grip. We are working closely with our primary care and secondary care colleagues. We are supporting them with additional pharmacy staff, and we have agreed on locally enhanced services with general practitioners. Locally enhanced services are about focusing on areas where we are outliers in prescribing. NHS Borders is an outlier in relation to gabapentinoids as well as antibiotics. In primary care, we will be looking at those areas in particular. We are also looking at areas where there might be medicines of limited value, and we are working closely with GPs on that.

In secondary care, we are looking in particular at biosimilars, which are extremely expensive—they are increasingly effective, but they are not funded through the prescribing budget allocations. Even though there is now more access to such drugs, we need to look at whether our consultants are really drilling down in those areas, particularly in relation to moving from proprietary drugs to generic ones.

We are engaged in joint collaborative work with our primary care and secondary care colleagues to focus on this really important area, which is responsible for a quite significant part of the overspend.

The Convener: Does that suggest that there has not been a sufficient level of monitoring and management of demand in the past?

10:30

Dr Patterson: There did not used to be access; as I said, the Scottish Medicines Consortium used to focus purely on the evidence base—on quality-adjusted life years, in particular—so any drug that would deliver on £30,000 per quality-adjusted life year had to achieve the criteria. Access has been significantly increased. We are a democratic society, and I understand why there is a discussion with politicians and the public about what they want with regard to new drugs. The significant increase in access, to deal with not just quality-adjusted-life-year costs but what patient groups and clinicians think, has kick-started the increase in spending on secondary care that we are having to deal with.

The other factor that is driving our prescribing is the significant increase in the number of elderly people, particularly in the over-65s, as John Raine said. Primary care list sizes have gone up by about 2 per cent, but the number of over-65s on general practitioner lists in the Borders has gone up by 26 per cent, and the numbers of over-75s to 85s and over-85s have gone up by 12 per cent. Those are significant increases. Most older people have not just one but multiple diseases or morbidities—they may have four to deal with. That has put a lot of work and stress on our GPs. There is concern in the Borders and elsewhere about the huge amount of staff stress. A third of GPs say that stress to do with capacity and workload and prescribing costs is driven in primary care by older people with multiple comorbidities. It has been good to increase our life expectancies, and we are trying to increase healthy life expectancies, but that has been a factor.

The Convener: Your point is understood—thank you very much.

Emma Harper: Good morning, everybody. I am interested in exploring further potential ways to save costs or to deal with the difficult decisions that might have to be made in order to support better practices or processes. I was interested to hear that you shared your train journey with somebody who has worked at NHS Borders for eight years, whom nobody knew. A consultant works at a level at which I would imagine there should be some leadership engagement.

You will probably reflect on that, but what processes do you have to engage directly with the workforce, whether nursing, allied health professionals or front-line doctors? You are

encouraging us to speak to the front-line people, when you do not even know a front-line person who has worked at your board for eight years. We know that many front-line staff have good suggestions for support, savings and measures that will help. What do you do, or what plans do you have, to engage with them?

John Raine: I will start off and then colleagues will add to what I say. Although we did not know the individual in question—he works part-time at the hospital, in a function in which we would not ordinarily see him—we take very seriously the appointment of consultants. We probably have the lowest vacancy rate in Scotland—it is only a few per cent, and the vacancies that we have happen to be in the specialties in which there are shortages. With regard to the board, I chair the appointment panels for consultants, and Jane Davidson, the chief executive, and the medical director will always be there. That is a symbol of how seriously we take our consultant appointments.

When I came on the scene, I was very keen on how we relate to and encourage staff and support their wellbeing, because I had seen what was done in the NHS areas where I had worked in England. We need to recognise staff achievement not only by saying thank you directly, but in a public setting. I will touch on a couple of initiatives.

For the past five years, we have run an annual staff awards celebrating excellence function. Christine Grahame knows that, because she has attended as a guest, and she will undoubtedly vouch for the fact that it is a big event that is attended by nearly 400 people and that it is run very professionally. It gives us an opportunity to recognise staff, partners and the wider community. In addition, I write personally to everyone who is retiring from the organisation. You might say that that can be done only in a smaller board, but I think that it is important to acknowledge people who, in some cases, have given a lifetime's service to the NHS; they should at least get a letter from the board to say, "Well done." We put on an annual, low-cost tea party for people who have retired. Again, we can do that because we are a smaller board. I think that that is important.

Nicky Berry can talk about what we do when it comes to supporting nurses.

Nicky Berry (NHS Borders): I apologised to the chap we met on the train this morning because, like John Raine, when he said that he had worked at NHS Borders for eight years, I was shocked. I am very visible in the board area. I have been in his department, but it is one of the departments that I am not in regularly. However, his wife is another member of our staff, and I know her well.

I agree that we should be out and about and that we should know our staff. The chief executive opens every induction with a welcome. I have taken over that role and have done that since November. That involves me welcoming every member of staff who comes into NHS Borders, wherever they work. I think that that is important. It is also important that we meet every student nurse in NHS Borders, wherever they work, throughout their three years and that we keep up with them.

In relation to valuing our staff, we have a number of on-going initiatives. We have a wellbeing Wednesday, which the member of staff we met on the train talked about. As part of that, every Wednesday, there are new initiatives, such as mindfulness sessions, letters being sent to staff to thank them, fruit or bottles of water being left in places—just small tokens of appreciation—and so on. Feedback from the staff tells us that what they appreciate is not the fact that they get something but that the management are visible, that they ask people how their day has been and whether there is anything that they can do to help, and that they thank them for what they do.

Work is on-going but, again, the meeting with the member of staff on the train this morning was an example of the work that needs to be done. He works in NHS Borders, and I do not know him. I will email him today. On the back of what was picked up on through iMatter, that team has a coffee morning, for which it stops at 11 o'clock. I will make a point of going to that department twice a week.

Emma Harper: As a former employee of NHS Dumfries and Galloway, I think that it is fabulous that we celebrate our staff. However, my question was to do with what you are doing on the front line in relation to cost savings and difficult decisions that have to be made. Are you directly engaging with front-line staff in relation to finding ways to reduce costs?

Jane Davidson: We are talking to different groups of staff to replay what has been said about the financial position, in order to communicate that properly. We are trying to help them to understand the magnitude of the position, because it is pretty serious, and to engage with them, to see what their ideas might be. We are using our partnership colleagues, in particular, to do that. They are engaging with staff directly in order to see what ideas people might have for efficiency savings and what they have to say about any waste that they can identify. We want to get their ideas about what might need to change. That has been important work.

The biggest potential changes are not going to involve small things in our control or small improvements, but those things are important. Everything adds up, which means that all the

ideas that are coming through need to be heard and responded to.

Most of the change will be in our clinical models and how care is delivered going forward. That change will need to be quite bold. We do not necessarily know what that is going to be, but it will be informed by some of the ideas or insights that the staff have.

I will bring in Carol Gillie, and possibly Rob McCulloch-Graham, if he wants, to speak about what is happening in the community around engaging with staff and garnering ideas about the financial position.

Carol Gillie: I go back to what I said earlier about some of the changes that we have made. We set up a project management office, which has five workstreams that actually deliver schemes, report on them and provide data. One of the workstreams takes ideas from our staff and clinicians, by way of the engagement that Jane Davison referred to, which we review in a methodical way; we then feed back to staff on whether there is something that we can take forward. Therefore, we have a process to try to get those ideas from the front line.

On the question about difficult decisions, I referred to our new governance arrangement in relation to turnaround. We have set up a governance framework, and every scheme that comes forward will go through our area partnership forum and the clinical advisory committee, which involves clinicians coming together to review any ideas that we are taking forward, so that we can highlight risks or issues to the board before decisions are made. Therefore, we are trying, in a very open and transparent way, to make sure that across the organisation we engage with ideas that will potentially go forward.

Rob McCulloch-Graham (NHS Borders): I would not want the committee to get the impression that none of that work has happened in the past. The board has been successful in producing a balanced budget in the past, but it has had to make non-recurring savings, so there has been a build-up of a gap, which we are now facing. Bold Revolutions is coming in to support us but it is not the cavalry coming across the hill—it is joining with us to see how we develop the work that we are currently doing.

I will give a quick example. I have been with the board as chief officer for almost a year and a half. We listen very closely to all our workers and to our patients—the people who use our services. Just over a year ago, we introduced a new service called hospital to home, to try to alleviate some of the delays in both our community hospitals and our general hospital. That involved working with our care organisations, our patients and our district nurses to design a new initiative to support patient flow, with a direct consequence for expenditure in that area. The service was introduced just over a year ago and is now running across the Borders, in all five of the localities in which we operate. It has capacity for up to about 70 patients, and we have seen a significant difference between the winter that we have just had and last winter. That initiative happened on the back of comments that we received from staff and it has been welcomed by staff.

When I joined NHS Borders, I noticed the engagement with the partnership and with the staff unions in the council. There is a joint staff forum, which has been in existence for several years, where unions from the council and NHS Borders meet monthly, and I attend those meetings as often as possible. We take the unions through the initiatives, we listen to them and we jointly develop things with them, which helps the introduction and implementation of those initiatives.

Emma Harper: Christine Grahame asked about specific examples, so I will mention one that I am aware of. Pulmonary rehab is part of a process for people who have chronic obstructive pulmonary disease that works in other health boards to keep people out of hospital. The process also includes increasing the uptake of the flu vaccine and smoking cessation. That really works, and pulmonary rehab is cheap. What progress has been made in NHS Borders with such processes?

10:45

Dr Patterson: I entirely agree that such a process works. Chronic obstructive airways disease is a chronic, life-long condition and we want to support people with the disease so that they can live in the community, which they want to do.

This year we have initiated a project, into which we have put significant funds, to support the pulmonary rehab programme. That will mean recruiting additional staff, particularly physiotherapy staff, and focusing on supporting people in the community with medication compliance so that they can live where they want to live and avoid hospital admissions. I agree that the evidence on that is pretty strong. We have prioritised that project, which flowed out from our clinical strategy, which identified chronic obstructive airways disease as a key illness to address, along with diabetes. Those are the two areas that we are focusing on, and I fully support that work.

Efficiencies have been mentioned. You must remember that it is the clinicians who commit most of the resources. You are probably aware of the realistic medicine initiative, which is one of the

areas on which Catherine Calderwood, the chief medical officer, has been leading and which is about reducing risk and harm to patients, reducing variations in care, prioritising best practice and supporting self-management. Our GPs and hospital clinicians are leading on that work. It is probably one of the big priority areas in which we will be able to generate significant savings.

We have a good structure in place in the east of Scotland. We are working across the three health boards. The medical directors meet regularly and they have identified prescribing, frail elderly patients and end-of-life care as areas where there is a lot of cost. We have local projects and a local lead for realistic medicine. We are working with anaesthetists and our palliative care services to decide how to engage with clinicians and families about anticipatory care plans for end-of-life care.

We have a big national project called respect, which supports anticipatory care planning. We ask patients and their families whether they want a curative-type treatment or a comfort-type treatment. That is an area where some of the real cost savings could come in. It was not really on the agenda until Catherine Calderwood pushed for it. We now have posters up in out-patient departments and we give leaflets to patients. Our GPs are fully on board with that. It is a really fruitful area for us. If we focus on variation and what patients actually want, that will help generate savings and provide really excellent care for patients and their families going forward.

The Convener: I want to go back to a couple of financial points. I noticed that there was a proposal to transfer £1 million or more from capital to revenue. Does that create risk, given that you have one major hospital, which is of some age, and there are clearly capital programmes that need to be invested in? What are the implications of that proposal for the healthcare environment at Borders general hospital?

Carol Gillie: Colleagues have referred to the non-recurring measures that we are taking to deliver financial balance. You are correct—the measure that you refer to is one that we have used for the past couple of years. NHS Borders gets its pro-rata share of the capital formula allocation that exists across NHS Scotland. It is about £2.4 million for us, which is not very much money, but it helps us keep the estate at a decent standard.

Our backlog maintenance level is £8.4 million. That is a big amount of money, but compared with other boards, on a pro-rata basis, it is at the lower end. We have managed to keep our estate at quite a high standard. Backlog maintenance is split into four categories. I am not sure whether the highest one is called “high” or “significant”, but none of our backlog maintenance is in that category; it is all in the three lower categories. I emphasise that we have managed to keep our estate in a fairly good condition.

Where NHS Borders has been successful is in bidding for additional resources. That is a tack that we have taken, and in recent years we have managed to get significant investment in our information management and technology infrastructure and an investment programme across our primary care premises. In this current financial year, we have managed to get additional funding for IMT and to secure another MRI scanner. There is a risk, but we have been very successful in getting additional resources, from the capital perspective, into NHS Borders, which has offset and mitigated that risk.

The Convener: This is my final question on finance. I believe that there is a £7.5 million overspend for the health and social care partnership. Where will that money come from?

Carol Gillie: I will ask Rob McCulloch-Graham to come in on that in a minute, but our scheme of integration—the way that we do business with the IJB—sets out what happens with that overspend. Basically, the IJB is supposed to come up with an action plan to address the overspend. If that is unsuccessful, the IJB can come back to either of the parent bodies—the council or us—and ask for additional cash to offset the pressure that it faces. That is the situation that the IJB is in this year, and we have agreed to give it additional support so that it can deliver on its financial targets.

The Convener: Will that be 50:50 from the council and the health board?

Carol Gillie: The rules in our scheme of integration are that the IJB goes back to the relevant parent body, depending on where the pressure is. This year, the main financial pressure for the IJB is with the NHS, so the NHS is coming up with the majority of the support. Rob McCulloch-Graham may want to comment further.

Rob McCulloch-Graham: Additional money has been going into the health and social care partnership from the council. An additional £3 million came in during this year, and the budget has been rebased. We are facing particular challenges with the population, which Tim Patterson touched on. We project a 100 per cent increase in the number of over-75s by 2036, and we are beginning to feel that increase now. Year on year, we are facing greater demand for our services.

We carried a shortfall of £4.8 million last year from unmet savings, so part of the £7 million that the convener referred to is the £4.8 million, which has been carried over from last year. We are facing significant challenges and we will address them over the long term. We know that it is more

expensive to care for people in our health facilities than in our care facilities and that we currently have an imbalance between those, so we are undertaking work to see whether we can shift the balance of care. We have undertaken several pieces of work over the past year to try to identify what that number is and we will be redressing the balance between the number of care hours that we provide at home and the number of care beds that we provide.

We face a challenge with the number of nursing beds, particularly for advanced dementia cases. We have invested a further £0.5 million this year in opening more beds in one of our excellent nursing homes, which has reduced the pressure on one of our mental health wards in the general hospital. We expect to do more of that over the next two to three years, to try to shift the balance of care. That does not mean that we will make savings on any beds that we can close, because we need to carry investment into council services. A proportion will go towards providing a balanced budget, but we need to make sure that we shift the investment across so that there is capacity in our social care providers.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, panel, and thank you for coming to see us.

I want to ask about leadership. In John Raine's opening remarks, he referenced the fact that he and Jane Davidson are both about to leave through planned departures. I absolutely accept that that is entirely their right. However, there is a rather worrying trend of leadership churn in our health boards in Scotland. We are starting to feel that some of our health boards are almost ungovernable; that is becoming a prevailing view, perhaps unfairly. What reassurance can John Raine and Jane Davidson give their successors in this difficult task?

John Raine: That is a good question. Jane Davidson was good enough to give us six months' notice of her intention to retire, which meant that we have been able to recruit a chief executive—Ralph Roberts will be joining us shortly from Shetland. We had a very good shortlist and a lot of interest—there were 20 to 30 applications. There is still an appetite out there among professionals in England and in Scotland to bid for chief executive jobs.

There is no permanent replacement for me as chair. The vice-chair will be acting up from the end of this month. Of course, the recruitment of chairs is not a matter for the board; it is a matter for Government and the public appointments unit. A recruitment exercise for a number of chair vacancies was conducted at the back end of the last calendar year, and I was informed on 21 December that it was not successful in attracting anybody to replace me at NHS Borders. I understand that the arrangements for re-advertising are likely to start any day now and will involve vacancies in the Borders and perhaps three other areas.

In a way, that is disappointing. The position of chair in an NHS board in Scotland is an extremely good one; it is challenging and tough, and although there have been some lows—we are currently going through a low—there have been a lot of highs as well. I would commend the role to anybody who feels that they have the competencies to have a go at it. I have been a non-executive in England and Scotland for 21 years, and I have held three chairmanships. The system in Scotland is extremely good and I have enjoyed my time. It can be high risk, and people see that there is a reputational risk for senior people in the NHS—for both executives and non-executives—when things go wrong, which might be a deterrent. However, I would encourage anybody to have a shot at it; whoever succeeds me will be in for a pretty stimulating time.

Alex Cole-Hamilton: Before you bring in Jane Davidson, convener, I will ask a follow-up question as a result of John Raine's comment. It is great that you gave so much notice, Ms Davidson, because a lot of succession planning can go into that. However, it is uncommon to lose both the chair and the chief executive at the same time. Are you therefore content that you have built into the systems and the people around you that continuity of organisational memory, in terms of the shared vision of where the board needs to be?

Jane Davidson: I suppose that you might be better asking colleagues around the table about that particular point. However, I will address it. There was a high level of interest in the chief executive post from people who are already in the health and social care system. I do not think that the desire to aim for a chief executive or senior manager role in NHS Scotland is lower—certainly not with regard to the Borders job. The Borders is a great place to work. I told everybody who contacted me to ask about the role that the Borders is a tremendous place and the people who work in NHS Borders are absolutely fantastic. I could only commend the role. That is not to say that it is not incredibly challenging, but it is also very rewarding.

Over the next year or two, we are probably talking about making bold changes, as Audit Scotland has said, because the demand for health services is outstripping the resources that will be available in the public sector environment. That is understood, but it will bring a level of excitement and innovation to the environment that will be really welcome.

On whether I am ensuring that there is organisational memory, I would say yes, I am. The people in the executive team have organisational memory. There are some long-serving executives, and they have been working very closely with the more recent executives—we have been doing that even more over the past six months—to ensure that people absolutely understand where we are at, so that it is not all in one person's knowledge base.

For the past six months, I have been ensuring that my colleagues are absolutely involved in decisions and management pushes or actions that I would otherwise have just cracked on with. I have been involving them and taking them along with me in my thinking around all that.

We are very fortunate that Ralph Roberts used to work in the Borders and although it is a different organisation from the one that he left, he has knowledge of the people who are around me today, which will be incredibly helpful.

11:00

George Adam (Paisley) (SNP): Good morning. I would like to follow on from Alex Cole-Hamilton's questioning, although I will take a different tack.

John Raine mentioned that special measures were being taken and that you cannot balance the budget at the moment. Given that you are leaving, that the chief executive is retiring in April and that the director of nursing and midwifery left in November 2018, my gut instinct is that the organisation and the management team are struggling or that there is a lack of leadership. Is that the case, or can you provide another explanation?

John Raine: I certainly do not believe that that is the case. Perhaps I ought to make it clear that I had no option: as I have come to the end of my second appointment term and have completed eight years, there is no way that I would be able to continue.

One of the challenges that we have as a small board is that we are seen as a ground for staff to develop and move on to bigger boards. In my time, we have had four medical directors, two chief executives and Nicky Berry is the fourth director of nursing, midwifery and acute services. It could be said that it is a healthy thing that people move on to bigger and better jobs or retire, so I do not see that as a worry. There are still senior people who have been with the organisation for a long time who have a corporate memory—Carol Gillie is one such person, and I think that Nicky Berry has been an NHS Borders employee for many years. Further down the management chain, there are people who have long experience.

However, there is an issue to do with the fact that we are a small board and people will look to progress and become directors of nursing or medical directors in larger boards.

George Adam: That is the first time that I have heard a health board compared to a provincial football club, where people start off their careers before looking for a bigger team.

John Raine: But without the rewards and the bonuses.

George Adam: You said earlier that you have owned the problem and that you owned the solution, but you seem to be taking the same tack. You also said that you would like to stay at the board, if that was possible. If you stayed, what would you do differently?

John Raine: We owned the problem, but—I think that I hinted at this—we tried to own the solution for too long. If I turn the clock back a bit, I think that it was up to me to elevate the seriousness of the financial situation rather earlier than we did. I am struck by what the committee said in its governance report, in which it talked about the need for health board executives and non-executives to speak up. Sometimes, there is a reluctance to do so, because there is an in-built protective instinct, whereby people feel that they can solve the problem among themselves. People do not want to discuss bad news, but there comes a time when they have to.

George Adam: If you owned the solution, surely your professionalism would kick in at that point and you would say, "Right—I need to sort this."

John Raine: Yes, I agree. We owned the solution for a period of time, after which it got to the point of being unmanageable.

We have put a lot of governance into our efficiency programme. Some years ago, I established a select-committee type of arrangement, which involves a finance group of non-executive directors holding managers and executives to account for the delivery of the efficiency programme. That group meets regularly. Staff come in to explain how they are getting on, where there are problems and what the board can do to unlock those problems. We have now converted that sub-group into a fully-fledged committee of the board—a finance and resources committee—to re-energise and put more effort into finance governance and to take some of the weight off the board, because its agendas have, in the past 12 months, been dominated by finance issues, although we try to keep the primacy of quality and safety high up on the board's agenda.

Bob Doris (Glasgow Maryhill and Springburn) (SNP): There are clearly financial challenges for the board. One aspect that we want

to look at is the costs that you accrue, and one of those is the cost of agency staff. A variety of reasons are given for the use of agency staff, including sickness absence cover, patient acuity and vacancies. I will not go into sickness absence cover, because one of my colleagues wants to ask about that. I will ask a more general question. The cost of agency cover is more than £3 million a year. Are you starting to get that spend under control? Can we expect it to reduce? If so, by how much, and what are you doing to make that happen?

John Raine: One of our biggest areas of overspend is nursing costs and the use of agency staff. Nicky Berry can explain what has been happening to reduce that overspend.

Nicky Berry: Like every other board in Scotland, we have had issues with recruitment of nurses. We have been extremely proactive, as it is not just a question of recruiting student nurses from higher education institutions. It is also about growing our own staff.

We have had a number of initiatives that have looked at the skills mix and considered how, if we cannot get registered nurses, we can deliver care differently. This year, we have trained healthcare support workers. We have worked with one of our local colleges, and we have band 2 healthcare support workers who are training to become band 4 healthcare support workers.

We have also been working with our higher national certificate students, with the Open University and with the return to practice programme in order to manage the vacancies. At present we have 23 registered nurse vacancies across NHS Borders, the majority of which are in the acute setting of the Borders general hospital.

We had an extremely successful recruitment in the middle of February, in which we interviewed more than 30 student nurses, and we have appointed to 30 posts. The student nurses will not get their registrations until September, but we will do what we did when we brought such people in as band 4s last year. They were management students one day and in the bank as healthcare support workers the next day. We recognised their skill set. We developed a framework of competencies, and they were supported by the practice education facilitators. Our appointees will go into the wards that have registered nurse posts and they will be there as band 4s until their registrations come through.

On the agency spend, we have been running the nursing and midwifery workload tools and looking at the establishments on the wards, using professional judgment, because we need to make sure that we know the right staffing levels for the wards. We have been working closely with our senior charge nurse on rostering. We have been looking at the basic management principles of rostering and managing the rosters on the wards, including annual leave. Sickness absence is another aspect—I know that Brian Whittle wants to ask about that. The standard is 4 per cent, whereas nursing and midwifery sickness absence in NHS Borders is at 6 per cent.

Over the past year, I have personally taken every phone call on agency staff in NHS Borders. We are beginning to see a reduction in our agency spend. At the end of the previous financial year, our nursing agency spend was £1.2 million. At the end of the current financial year, it will be less than that—it will be just under £1 million.

There is still a lot of work to do, but our focus is on ensuring that we have staff in post and are not relying on agency staff. We are also looking at our supplementary staffing, which includes our nurse bank.

Bob Doris: So, 23 vacancies are currently being filled by bank or agency nurses, unfortunately on a longer-term basis, and 30 band 4 posts are going to be embedded in acute wards by around September. Is that right?

Nicky Berry: Those registered nurses will be in place in September.

Bob Doris: Are you suggesting, then, that there will be more nursing vacancies by that point?

Nicky Berry: No. We have things such as the return to practice programme, we have staff who are doing Open University courses and we are looking at how we might have a different skills mix from bands 2 to 4. We are doing multiple things.

Bob Doris: Can I just check something about the 23 vacancies? My wife is a band 5 nurse in NHS Greater Glasgow and Clyde. If you have a newly qualified band 4 nurse coming in when you actually need an experienced band 5 nurse, you will still have the same level of vacancies as far as the skills mix is concerned. The 30 posts that you have mentioned are welcome, but my question is this: what will be the vacancy level in September? You have said that there are 23 vacancies at the moment, and you have mentioned another 30. From the outside looking in, it seems that those vacancies will just disappear. What will the vacancy level be in September?

Nicky Berry: I do not know, but I can get that information to you.

Jane Davidson: What we can say is that there will be a vacancy level, because we expect that there will be turnover. We are trying to minimise vacancies with the recruitment approaches that Nicky Berry has just highlighted.

I do not think that we have the sort of forecast that you are asking about, but we quite regularly have a vacancy level of about 20 with turnover, retirements and so on. We just need to minimise that.

Bob Doris: It is fine to have 20 vacancies for a couple of months while recruitment is going on, but an enduring vacancy level of 20 is actually a hole in the service. I am not clear how any of this will benefit us. Do you really not know what the vacancy level is projected to be later in the year?

Nicky Berry: We have a turnover of 2.6 registered nurses per month. We have had a mass recruitment, but we also have on-going recruitment. It is not as if we are waiting for this mass recruitment to come in in September; we had an opportunity to recruit from universities and other newly qualified staff, but we are recruiting outwith that, too.

Bob Doris: I just want to pursue this a little bit more, convener. I get the fact that there is attrition through severance, retirements, nurses moving to a more senior bank position or even to other health boards and so on. It is very helpful to know that the attrition level is, but are you managing it? You are suggesting that the vacancy level is 23 nurses, but is that not separate from the attrition level?

Nicky Berry: Yes.

Bob Doris: So, we can discount the attrition rate with regard to the underlying level of vacancies, which is 23. Jane Davidson has suggested that after these 30 posts come online later in the year, the level will drop to around 20. Is that not still significant?

Nicky Berry: Yes, and we recognise that we have a significant issue in that respect. If we are unable to source the registered nurses whom we need, we will have to look at our skills mix. In fact, the issue is not just the skills mix, but how we recruit and retain staff and reduce sickness absence, which obviously has an impact on the wards. There are multiple things to take into account—there is no one solution. It is not just about the students coming out of universities, but about what the workforce in the Borders needs to look like.

11:15

Bob Doris: I have a final question, which I would be happy for the panel to follow up in writing, given the time constraints.

I have always been apologetic when I ask this question. However, one of the biggest risks for the public sector is uncertainties over Brexit. I am not going to make a speech about Brexit, but I know that local authorities and the Convention of Scottish Local Authorities, for example, are scanning ahead to see what the risks look like, whether in relation to European nationals leaving or recruitment that is dependent on European Union nationals. A lot of agency nurses will be EU nationals. Has the board written to its EU national nurses, for example, to say, "You are welcome—please stay. What can we do to retain you?" What is the health board's exposure to the Brexit uncertainty? What is it doing to deal with the challenges? I will not ask any more, but it would be remiss of me not to raise the question in this context.

John Raine: We will reply to that. Tim Patterson is our resilience champion and knows about the Brexit preparations.

Dr Patterson: With Brexit, we hope for the best and plan for the worst. A lot of planning has been going on. Each board has a Brexit planning group, and ours is chaired by the director of workforce. We have undertaken a survey of any EU national workers who may be affected. We are making sure that they have full information and are supporting them, particularly in applications for the settled status scheme. The number of EU nationals in NHS Borders is small—we have identified 57 people—but I can reassure the committee that we are active.

A lot of Brexit planning is going on in other areas. Our multidisciplinary Brexit planning group includes pharmacy input to talk about medicines. The Scottish and UK Governments have not asked boards to do anything specific on medicines. The manufacturers, rather than the boards, will stockpile to cover a six-week period. We have looked at our contingency plans, particularly on food and supplies, and already have business continuity plans to cover that. We work with our partners in the council, who are active and concerned about Brexit, particularly the impact on small businesses and the farming community.

Our preparations are well advanced and we are working with our partners. We now report to the Scottish Government's health resilience group regularly and flag up any issues, so that the group can consider the implications for the NHS across Scotland of anything that we report.

The Convener: Thank you. A brief note on the staff survey would be helpful.

Emma Harper: I have a supplementary to Bob Doris's question. I thank Nicky Berry for her answers on sickness and absence. Is the turnover of 2.6 nurses per month in acute care, primary care or across the board? Is it in a particular area? Are there any trends in where that turnover is?

Nicky Berry: Most of the vacancies are in the acute division, which has the biggest nursing

workforce. There have been a large number of retirements, and we factor that in. There is not any trend. We are at the point where it is not an employers' market but an employees' market. Some nurses move within NHS Borders, because there are vacancies. The choice is there, and it is also there across Scotland. When I qualified—and, I am sure, when Emma Harper qualified—there was not the choice that there is now.

The issue is how NHS Borders makes itself attractive. I meet every student nurse who comes into NHS Borders to ask how we can be attractive and how I can make sure that the nurses get the best experience that they can. What do we need to do differently? What type of job would the nurse like? Does the nurse want a rotational post? I do not see a trend—retirements are one of the main reasons for turnover, but there is no other trend.

David Torrance (Kirkcaldy) (SNP): To go back to Brexit, Tim Patterson spoke about the stockpiling of medicines. Has work been done on the cost of medicines coming from the EU and the impact that that will have on the board's budget in future years?

Dr Patterson: I mentioned that management of that is for the UK and Scottish Governments. Their advice to us is to be aware of what is happening, and the Governments will provide us with advice. I do not have that information; that would be considered at the UK and Scottish Government level.

Brian Whittle: I listened carefully to your responses to Emma Harper's question on your interaction with staff, and to Bob Doris's line of questioning. You have a long-standing high sickness-absence rate, which suggests that the system is under pressure. That issue has emerged in our questioning of many of the health boards. I marry that up with your off-the-cuff account of the consultant whom you met on the train on the way up here, who suggested that the working environment is a very positive one for your staff, notwithstanding the fact—I am sorry to say this—that six members of the board did not recognise a consultant who had worked for them for eight years.

My concern is about your interaction with staff. The system is under pressure, I suggest, in terms of recruitment, retention and the high sickness level.

John Raine: For clarity, I note that there were only three of us on the train this morning, not all six of us.

Nicky Berry: Last year's statistics show that our sickness absence rate at NHS Borders was just below the Scottish average. However, we have a higher rate in nursing and midwifery—it is 6.49 per cent—and we are looking at that. Across every board, the sickness absence rate for nursing and midwifery is higher than the national average, which is 5 point something per cent.

We are making sure that we are being a decent employer—that people have return-to-work discussions when they come back, that we are following the sickness absence policy and that we have flexible working. About 45 per cent of the nursing and midwifery workforce in NHS Borders is aged between 45 and 55. How are we supporting those staff? Occupational health and safety services and our wellbeing Wednesdays are ways of doing that.

While we were coming up on the train today, we discussed a hydration station, and the member of staff whom we met on the train asked, "What do you mean by that?" It is about a ward clerkess, as a first point of contact on a ward, having a jug of water and saying, "Can I give you a drink?" when someone comes into the ward. It is about people's wellbeing, and the team's.

We recognise that there is sickness absence and it is higher than we would like, but we are actively working on that. That also relates to where we are for our financial turnaround because, if we look after our staff and take care of them, we will have reduced cost pressures from supplementary staff and agency staffing.

I hope that I have answered your question. It is challenging. We are not alone and we are not going to fix it overnight; we need to keep at it. It is about the wellbeing and the resilience of our staff, and it applies across NHS Scotland.

Brian Whittle: You are right—you are not alone. I have worked with NHS Ayrshire and Arran, and it has a similar issue. A chat with it might be helpful, because it has managed to turn its situation round.

We have heard over and over again that we have an ageing workforce with a lot of staff aged 45 to 55. I am sorry to describe those people as being older. However, we have always known about that. Nobody has quite answered my question on it. Why we have not planned for that?

Nicky Berry: We did plan, but I am not sure that we planned for nurses retiring at 55. We have planned for the workforce, but did we consider the special class status that means that staff can retire at 55? Did we appreciate how many nurses would retire? I do not think that we did. The focus might have been on students coming in. However, we need to think differently, because we cannot just depend on student nurses. We need to think about what we need from our workforce in the Borders from the point of view of health and social care.

The situation is changing, for many reasons. It is changing financially, and also because people

want to be looked after at home instead of in an acute setting. That means that we need to have a workforce that is designed to deliver that, rather than one that is designed to deliver acute nursing, which is what we have had for many years.

As I said, we probably did not appreciate how many nurses would retire. We have planned, but things have changed over the years.

John Raine: The issue relates to the wider question of the recruitment, training and education of the NHS workforce. Jane Davidson might want to comment on that.

Jane Davidson: It is really a question of national workforce planning. A workforce plan is due for publication quite soon, which will take us forward.

As Nicky Berry says, there has been an impact as a result of the appreciation gap in relation to how people want to live their lives—their working lives as well as their later lives. However, if you look at certain disciplines, such as radiology, as well as nursing, you can see that having enough people coming through the pipeline is definitely a challenge across Scotland and the United Kingdom, as well as internationally.

Miles Briggs (Lothian) (Con): In your submission, you point out that NHS Borders is reliant on NHS Lothian for some specialist cancer treatment. How is that negotiated?

Dr Patterson: We have regional planning, and NHS Lothian is our provider for specialist cancer care. We work through the south-east Scotland cancer network—SCAN—which is a managed clinical network that has been in operation for a number of years and has worked extremely effectively.

I mentioned the pressures on acute sector prescribing. You might be referencing some of the more expensive cancer drugs, which are putting pressure on the prescribing budget, particularly in secondary care. All of that is managed through the peer-approved clinical system tier 2 panel, which NHS Lothian uses. It makes recommendations and we listen to its advice. With regard to using those really expensive drugs, our system involves us listening to advice from SCAN and the Lothian PACS tier 2 panel.

If drugs are not approved by the SMC, they go to that panel. The decision is not just made around effectiveness and cost-effectiveness; it also involves consideration of what the public feel and particularly what the clinicians who are managing the patients feel. That system involves much more open access. The SMC open-access agenda and the PACS tier 2 panel, which deals with drugs that have not gone through the SMC, have increased the pressure on prescribing, and that is not currently funded. There have been policy changes without commensurate funding coming to the boards that have to apply the policy.

11:30

Miles Briggs: My question was more to do with surgical procedures than drugs. In your written submission, you say that the board monitors the situation to ensure that NHS Borders patients are not disadvantaged. I am a Lothian MSP and I know about the pressures that the cancer centre is under just for Lothian patients. Currently, only two slots are provided for out-of-board-area patients. What monitoring takes place for patients? There is no further detail on that.

The Convener: Who is responsible for that?

Jane Davidson: Patients with cancer are tracked individually—our waiting times team manages that patient by patient. We have really good relationships with NHS Lothian. In the network that Tim Patterson mentioned, our clinicians have great relationships, but so do the teams who manage the process. That is how it is managed. There is also a certain amount of anticipation and forecasting, and we are built into NHS Lothian's planning.

Miles Briggs: There is discussion about a new, replacement cancer centre for the whole of the eastern region. Given the budget pressures that we have heard about, funding the centre in the future will be a significant matter for all the health boards. Are you already part of that discussion? Has any commitment been made?

Jane Davidson: We are part of those discussions, but we are also ensuring that what we provide in the Borders is sustainable, expanding and robust. We are doing both things. Carol Gillie can give the committee more detail on the finances.

Carol Gillie: I go back to what I said earlier about capital funding. When we bid for a significant amount of capital funding, we have to go through a process, and part of that is that we have to get regional approval. We have very much bought into the agenda. We are looking at the future of the Borders general hospital and the cancer centre at the Western general hospital. We are working jointly with our regional partners to prioritise which schemes should go forward on behalf of the region.

Miles Briggs: I want to go off-piste, as it were. In September, Scottish Borders Council made a statement on the merging of NHS Borders and the council. Do you have any thoughts or views on where that is going? Many health boards that come to the committee do not have the advantage of having the same geographical area as their

local authority. Given what we have heard today about the radical reforms that will be needed in the future around not just financing but the delivery of services for an ageing population, what work is the health board doing on that suggestion?

John Raine: It is at a very tentative stage, but we have had preliminary discussions with Scottish Borders Council on further development of joint working between the council and the health board. We must bear it in mind that many of the functions and services that are needed to improve the health of the population and take pressure off health services lie with the council.

Tim Patterson is the joint director of public health with the council and the health board, and there is a good joint working relationship. We have had tentative discussions on whether we can build on that, taking the IJB model of improving health and social care services, but doing it collectively. My personal view is that we need to look at resources collectively rather than as a health board and as a local authority. As members will know, local authorities are responsible for a wide range of services that impact on health, from housing and planning to education and leisure, so the proposition that we should work more closely together has a great deal of validity.

We have had those preliminary discussions. The council was very keen to submit to the local governance commission for its report. That became public knowledge because it was taken through the council. Unfortunately, it caused some repercussions, because we had not even got to the point of discussing it as a board. It caused some concern to staff. We had to assure staff that we are talking not about a merger or a takeover by one of the other, but about better joined-up working for the benefit of patients.

The council has a notion that, ultimately, we could see a single public authority in the Borders. That may or may not be achievable. If it is achievable, I think it is way down the line. There are governance issues that would need to be dealt with, and so on. However, we have looked at relocating to council headquarters, where there is surplus accommodation, which we do not have, and having more shared arrangements with the council for central and support services.

There is a big conversation to be had about the development of local authorities and health boards to improve population health in the locality, and because we have a single local authority and a single health board, there is the potential for us to have a constructive conversation.

I think that Tim Patterson will want to add to that.

The Convener: I will bring in Rob McCulloch-Graham and then Tim Patterson.

Rob McCulloch-Graham: There is a long history of co-operation between the council in the Borders and NHS Borders, even before the IJB and the Public Bodies (Joint Working) (Scotland) Act 2014 were in place. Many services are jointly run. Our services for people with learning disabilities are an example of that, and some of our mental health services are run jointly, with joint budgets.

In the Borders, the council and the NHS are the two biggest employers so, logically, we need to work closely together, and I am sure that our working will get even closer in the future. The 2014 act provides a mechanism to expand that further. Talks are on-going around specific cases in which we share services, and I expect that we will share many more in the future.

Dr Patterson: I agree with Rob McCulloch-Graham. We must recognise that 40 per cent of population health is related to socioeconomic factors. The council has a huge role, including in employment, as has been said. The board and the council employ about 10,000 staff. We work collaboratively in dealing with upstream issues, including in particular early years, child health, and alcohol and drugs. The chief executive of the local authority, Tracey Logan, is extremely interested in health and she supports the joint collaboration. We must accept that there are different cultures, but she is keen to bring them together and particularly to see what opportunities there might be.

We are focusing on the public health opportunities, particularly around the new national priorities. Tracey Logan is now leading for the east of Scotland on diabetes prevention. When I think about my professional life, having a chief executive taking that forward, galvanising support in local authorities in the east of Scotland and getting involved in some of the more medical and health-related issues such as weight management is extremely welcome and very supportive. As John Raine said, let us see what other opportunities present themselves in the future.

Emma Harper: I am interested in the work on health and social care integration. Three IJB objectives are listed in our committee papers—improving the health of the population; improving the flow of patients through and out of hospital; and improving the capacity in the community for people who have received health and social care to better manage their conditions, and supporting those who care for them. There are also seven partnership principles, which are prevention and early intervention, accessible services, care close to home, delivery of services with an integrated care model, greater choice and control, optimising efficiency and effectiveness, and reducing health inequalities.

How do the three key IJB objectives and the seven partnership principles impact on how the health board considers performance and improvement?

The Convener: That is specifically about the health board rather than the IJB, I think.

Rob McCulloch-Graham: We reviewed our strategic plan last year and we refocused it down to those three clear objectives so that it helps to give that vision across all the services in both the NHS and the council. The idea is to provide better quality services under each of the objectives, but also that the objectives will drive efficiencies so that we are sustainable and can carry them forward.

You asked specifically about monitoring. In the IJB, we have a monthly monitoring report, we have committees set up and we report to both the NHS board and the council. The three entities—the IJB, the NHS board and the council—are kept abreast of performance across all those areas.

A number of activities have been brought into play specifically around those objectives and some funding has been allocated through the IJB over the past 12 months to support each of them directly. There is a list of those that we have funded. We mentioned earlier some of the pulmonary work that we are doing, which the IJB has funded directly. We have also talked about the hospital-to-home service that we have brought in, and we have looked at patient flow through all our acute settings.

The last objective is perhaps the most difficult one. It is to make sure that we have sufficient care in the community to look after people after they have been through our process. We are working closely with our council colleagues and the independent sector to make sure that there is sufficient care. One factor that we look at is the return-to-hospital rate, and the early findings from the hospital-to-home service show that it has been significantly reduced. We are looking to provide more services after health interventions so that we maintain people in the community.

The council is well placed to access what we are calling the community asset, looking at what communities can offer this agenda. The corporate plan from the council is based around the "Your part" campaign, which is about working with our communities and their residents—the citizens—to find out what they can provide to the agenda. We will help them to do that. The review of the strategic plan for health and social care has followed suit on that, so we expect to work with carers, other organisations and directly with the public to do that.

We operate in five localities, and that gives us great access to the communities in our five major towns. We have supported local working groups to help us to develop our policies and services. They are now active, we support them, and they have representation on the strategic planning group, so there is a good link.

Emma Harper: The committee has heard a lot about set-aside budgets and what they are used for. You mentioned that the IJB is funding pulmonary rehab, and Dr Patterson talked about diabetes. I should probably mention that I am the convener of the cross-party group on lung health, so I am keen to hear about any processes that keep folk out of hospital and support lung health. I am interested to know whether set-aside budgets are being used to support pulmonary rehab processes, if that is from IJB funding, and what specific activity is being directed at improving patient flow and reducing admissions across NHS Borders.

Rob McCulloch-Graham: I will hand over to Tim Patterson in a second, but the IJB funding is from the integrated care fund. That is flexible funding that we have been able to use to pump prime initiatives in the community. Other services in the community are funded from our mainstream budgets. It is not specifically from the set-aside budget. Do you want to add anything, Tim?

Dr Patterson: No.

David Torrance: How difficult is it for you to eradicate delayed discharges, because of the lack of care home places?

Rob McCulloch-Graham: We have done a huge amount of work around delayed discharges. It was a particular challenge, not this winter but the winter past. We had a very challenging time within our acute facilities and we learned the lessons from that. We did a review, on the back of which we introduced the winter plan for this year. It was particularly focused on patient flow, and delayed discharge is a close part of that.

We introduced a number of initiatives and expanded others around step-down care, intermediate care and getting people to their homes as quickly as possible. We set a direction for the NHS and the council around discharge-to-assess, because we firmly believe that the best assessment we undertake with patients is in the home. Therefore, we are trying to get the services out there.

We have also worked with our providers of care homes and of care at home to ensure that their systems are efficient and that we are getting as much of that provision as we are paying for. We are trying to increase the capacity that they can offer. One of the difficulties in the Borders is the rurality. There are great distances involved, so it is more expensive for us to provide those services than it is in a city such as Edinburgh.

We are looking at increasing the capacity in care homes and care hours, and we have more capacity this year than we had last year. There has been direct investment from the council, outwith IJB money, to fund some of those care places, and that has been a significant help with our elderly patients with mental health issues. Performance in that regard has been much better this year than it was last year.

Reducing delayed discharges is an on-going target for us. We want to get those down to zero. There has been a significant improvement this year. There has been an improvement of around 15 per cent in the length of stay in acute facilities and an overall reduction in delayed discharges of around 7 per cent compared with the same time last year. Compared with other boards and IJBs around the country, we are middle ranking.

11:45

David Torrance: You say that you are surprised at the increase in the number of under-65s who need 24-hour nursing care. How are their needs being met?

Rob McCulloch-Graham: They are being met in many ways. For care within the home, we have put in further services in the community. In the central locality—the Eildon locality—where there is not a community hospital, we have moved out some of our physiotherapists to work alongside our healthcare support workers. They are linked into our district nurses, and our GPs are operating within their clusters, too. There is a very strong partnership to make sure that we have the right people to give the right support in the right place at the right time. Co-ordination is vital to ensuring that we can do that within the funds that are available, and we constantly monitor that.

The advent of the primary care improvement plan is another bonus for us in seeing that through. Our GPs, in particular, are very engaged in that and they are leading on six of the programmes under that plan, which will address some of the issues that you have mentioned.

Miles Briggs: I am thinking of the patients who come to NHS Lothian for treatment. What are your cross-border arrangements like? Are you seeing an increase or a decrease in the number of patients who go to NHS boards in England for treatment or a response?

Jane Davidson: I am sorry—I am not clear whether you are asking about NHS Lothian or boards in England. Could you repeat the question?

Miles Briggs: I am acutely aware that patients in the Borders go to NHS Lothian for treatment, and I know that, increasingly, patients across Scotland go to Newcastle for treatment. Given the geography of the NHS Borders area, what is the current pattern? How is that treatment being financed?

Jane Davidson: It used to be the case that a lot of people came from England to NHS Borders, but that has tailed off over a number of years as the north of England has reorganised itself.

The flow from NHS Borders across the border mainly involves patients who require elective procedures for knees and hips and so on. The situation depends very much on whether we can source the capacity. For many years, it has been part of our standard operating procedure to be able to access services in other areas—in Newcastle, in particular—to support us with that. That is part and parcel of our planning to deal with waiting times. We factor in whether we have the resources available to do that. Sometimes, we get additional funding from the Scottish Government for extra waiting list initiatives. That has been the case this year.

Miles Briggs: Do you use Golden Jubilee capacity for such operations, too?

Jane Davidson: We use the Golden Jubilee hospital sometimes—it depends on what the procedure is. For some of our patients, it is easier to go to Newcastle. We have relationships with Newcastle and the Golden Jubilee, but we use the Golden Jubilee less than we did, because we are trying to do as much in house as we can.

Christine Grahame: Thank you for letting me in, convener.

As you know, I have been a critical friend of NHS Borders for a couple of decades, and I have a high regard for the staff. That said, I am sure that the witnesses will now check that they know all the consultants.

I seek clarification on a couple of points. I understand that there is joint working with the council, but can you confirm, for the record, that that does not mean that Scottish Borders Council is running NHS Borders or the BGH, which is what the papers said? That is what scared people.

Secondly, what has Bold Revolutions—what a name for a company!—said that you can do right away to make savings? I take no pleasure in the board's financial difficulties. When it comes to what you can do, let us exclude prescriptions.

The Convener: That was two questions.

John Raine: The answer to the first question is absolutely not. There is no takeover of health by the council. The NHS brand is sacrosanct.

Secondly, Bold Revolutions started work only yesterday, so we are waiting.

Jane Davidson: We have had the Scottish Government's board recovery team in since before Christmas to help us make sure that there is enough rigour in our approach, which is a project management approach. The team has brought its experience and expertise to us.

On our financial settlement for 2019-20, after we have paid for our pay awards, we are left with something like £600,000 to deal with other pressures—that has been the case for a number of years. Think about drugs costs, for example. That is a massive challenge for us. Bold Revolutions and the recovery team have set out their stall by saying that they will be able to help us to identify savings of 4 per cent, 5 per cent and 5 per cent over the next three years. In very broad terms, that would be something like £10 million each year. We do not know where that is coming from.

Our annual review from 2016-17 made it pretty clear that the challenge around public sector settlements across the sector would be pretty demanding. We are confident that we have about £8 million of what we need next year in the bag already. When we hit last year and looked at all the benchmarking, we were not prepared to class that as unidentified, because we could not see where the big, bold changes were going to come from. That is why we need assistance, which is very welcome. If we are able to achieve the 4 per cent, 5 per cent and 5 per cent, that will really make the difference. Bold Revolutions started only on Monday, but it and the experts from the recovery team are telling us that those figures are achievable, which we take confidence from.

Brian Whittle: I have a simple question. You are obviously working under a new GP contract, and there is a suggested disparity in acceptance of that between urban and rural areas. Given that you are quite a rural area, are the GPs in the Borders supportive of the new contract and everything that it entails?

John Raine: The short answer to that is yes, but I will ask Rob McCulloch-Graham to come in on that.

I have discussed this in the board and the IJB and the board accepts that it is impossible to overstate the importance of general practice in the sustainable, affordable services that we are trying to achieve. It is very much about shifting care and shifting resources, and general practice is pivotal to the success of that. We have 23 general practices in the Borders. We are working hard to sustain good relations with our GPs. That is work in progress.

Rob McCulloch-Graham will give you a bit more detail around the primary care plan.

Rob McCulloch-Graham: I referred to this earlier. As John Raine said, the GPs are a vital part of the work that we are doing with our communities in providing quality primary care and supporting our acute sector with admissions avoidance in the hospitals.

We held a development session last Monday at which the GPs were represented. All the delegated services in the IJB were covered. We looked at what the future holds and the challenges that we face.

It is true to say that the financial return from the new GP contract does not benefit GPs in rural situations as much as it benefits GPs in cities. Having said that, the GPs in the Borders welcome it. We think that it will allow them to free up time to get involved in the overall health agenda in their communities, which is to be welcomed. The GPs are an expensive but very worthwhile resource, and they work tremendously hard. We need to make sure that we use that asset more than we are currently using it.

In fact, at the meeting on Monday, one of the GPs made precisely that comment. GPs are looking forward to the time when some of their workload gets passed on elsewhere and they are freed up to do real preventative health and health support work in communities. I, too, am looking forward to that. One of the GPs I met said that around 50 per cent of their consultations were about mental health, and, in the main, all that they were doing was referring people to other agencies. That is just really expensive triage, and it does not utilise what the GP, as expert generalist, can actually do. That is what we need to move to.

The 23 general practices in the Borders are really keen on this. They were fully involved in the development of the primary care improvement plan, and, as I have said, they are leading on its six workstreams. With the plan's implementation, we look forward to moving certain tasks to other health professionals and elsewhere over the next couple of years to ensure that we make best use of GPs.

The Convener: How do you envisage tackling the problem of mental health referrals in rural areas? Will it mean more mental health nurses in practices? What is the plan for that?

Rob McCulloch-Graham: That would be one approach. GPs are working with mental health colleagues to ensure that services are more accessible to communities and are provided where the people are instead of their having to travel to them. Some services will be provided in practices, some in other services in the communities and some by the third sector.

Brian Whittle: Given what Mr Raine said about the importance of general practices in delivering

the sustainable model, how are you monitoring those practices? Does the new GP contract alter the way in which you gather that information?

Dr Patterson: The new GP contract has changed how practices monitor quality. Previously, we had the quality outcomes framework, and now we have what is called the quality cluster model. In the Borders, we have four clusters, each of which has a quality cluster lead; that will be a GP who actually has some time to lead on that—they probably need a bit more time, but that is another discussion. In turn, each practice has a quality practice lead, who previously will have looked at what was important to them in the quality outcomes framework. What we have now is actually an improvement, because we are looking at the local needs in an area, particularly with regard to long-term conditions such as diabetes, COPD and heart failure, blood pressure issues and what have you. They identify key areas that they want to work on, and they work on them with the practices; the health board can be aware of and support that work, too.

As Rob McCulloch-Graham pointed out, one key area is the new concept of expert generalist. The idea is that those people will really focus on the things that GPs need to work on, and one big development is that we are now looking at the work that others such as advanced nurse practitioners can do. They recognise that that is a key area of development and they are working with our director of nursing on a common training framework.

A lot of innovation is going on around quality enhancement. For example, there has been work with the Scottish Ambulance Service on undertaking certain calls, particularly in rural communities. The primary care contract has pushed a lot of those developments; as Rob McCulloch-Graham said, the primary care improvement plan will see vaccination and immunisation being taken away from practices over the next couple of years and a focus on pharmacy, musculoskeletal issues and physiotherapy; that will allow GPs to focus on the increase in elderly people that I mentioned earlier. After all, we are expecting the number of over-65s to increase by a third over the next 15 years and the number of over-75s to increase by 75 per cent.

Christine Grahame: I hope so. [*Laughter.*]

Dr Patterson: These are complex issues, and the clusters might be able to work together to ensure that, for example, warfarin clinics can be run or there is long-term management. It is not just the benefits that we can get now, but the benefits that we will get down the road, particularly with the real opportunities that are presented by new technology. I think that the contract will give us a good foundation as we move forward.

12:00

Brian Whittle: I have a final quick question. Has the money in the primary care fund been fully distributed? How much was in it?

Rob McCulloch-Graham: We did not use the full amount of funding in the first year, but what has been left has been transferred into next year, and we will be able to use that fully in 2019-20. I do not have the figures to hand—I will have to pass them to you later—but I think that the fund is just short of £3 million over three years.

Carol Gillie: We got around £900,000 this year. As Rob McCulloch-Graham said, we drew down only 70 per cent of that, which means that we are carrying forward 30 per cent. The fund increases to just over £1 million next year and up to £2 million the year after, so the investment that we get ramps up.

The Convener: I thank the witnesses very much for a very full evidence session and their comprehensive answers. We will want to come back to you on a number of issues that have been raised; indeed, you have already offered to give us more data on a couple of things. You will be hearing from us.

We now move into private session.

12:01

Meeting continued in private until 12:16.

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