OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 25 June 2019

Session 5

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HEALTH AND SPORT COMMITTEE
17th 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:

Paul Hawkins (NHS Fife)
Michael Kellet (Fife Integration Joint Board)
Rt Hon Tricia Marwick (NHS Fife)
Chris McKenna (NHS Fife)
Barbara Anne Nelson (NHS Fife)
Carol Potter (NHS Fife)
Anas Sarwar (Glasgow) (Lab) (Committee Substitute)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 25 June 2019

[The Convener opened the meeting at 10:00]

Subordinate Legislation

National Assistance (Assessment of Resources) Amendment (Scotland) (No 2) Regulations 2019 (SSI 2019/171)

The Convener (Lewis Macdonald): Good morning and welcome to the 17th meeting of the Health and Sport Committee in 2019. We have received apologies from David Stewart MSP, and Anas Sarwar is attending as a substitute member. I ask everyone in the room please to ensure that mobile phones are off or on silent and not to use mobile devices for recording or photography.

The first item on the agenda is subordinate legislation and consideration of a negative instrument. Under the National Assistance (Assessment of Resources) Amendment (Scotland) (No 2) Regulations, advanced payments to survivors of child sexual abuse who are over 70 or terminally ill will not affect local authority assessments for charging for care. The Delegated Powers and Law Reform Committee considered the instrument on 18 June and determined that it did not need to draw the attention of Parliament to the instrument on any grounds within its remit. If it is approved, the instrument is due to come into force on Friday of this week. As members have no comments, does the committee agree to make no recommendation on the instrument?

Members *indicated agreement.*

The Convener: Thank you very much.

Scrutiny of NHS Boards (NHS Fife)

10:01

The Convener: The second item on the agenda is an evidence session with NHS Fife. This is part of a series of evidence sessions that the committee is holding with territorial health boards. I welcome the Rt Hon Tricia Marwick, chair of NHS Fife—I will resist the temptation to add "MSP" at the end of her name; Paul Hawkins, chief executive, NHS Fife; Michael Kellet, director of health and social care at Fife Council and chief officer of the Fife integrated joint board; Carol Potter, director of finance and performance, NHS Fife; Barbara Anne Nelson, director of workforce, NHS Fife; and Chris McKenna, medical director, NHS Fife. I welcome you all to the committee and I look forward to your evidence.

I will start by asking about NHS Fife's financial position. In particular, what progress is the board making to ensure that savings are achieved on a recurring and sustainable basis?

Carol Potter (NHS Fife): Let me give colleagues in the room some context. NHS Fife spends around £2 million daily, providing health and care to the population of Fife. Over the last financial year, working with our staff, our budget holders and, obviously, the public, we have had strong and effective financial management and financial control, and we have delivered the financial targets once again without any additional funding support through brokerage from the Scottish Government. We have been very focused on balancing our financial position with our operational performance on waiting times and in other areas. As we go into the new financial year—we are coming to the end of the first quarter—the financial position is challenging; it is an absolutely prevalent issue, particularly in our acute services, where we are facing an efficiency requirement of about 6 per cent this year.

On a positive note, although there is a recurring gap in our financial position, since 2016, we have been moving, year by year, to reduce it. We started this financial year with a £17 million recurring gap—that demonstrates the move over the past few years. For the current financial year, we have been working to refresh what we call our transformation approach, working with colleagues in the health and social care partnership on a system-wide basis. Our medicines programme is a very good example of where Fife has delivered effective recurring savings through a system-wide approach. We have seen significant savings—of a magnitude of millions of pounds—by looking at our medicines waste and reviewing our formulary and formulary compliance. Our pharmacy colleagues

have undertaken a positive piece of work alongside our general practitioners and acute clinicians.

It is challenging, but we are making progress on good housekeeping, looking at all areas—procurement and supplies, for example—and getting into conversations about redesign and transformation, which some of my colleagues can comment on.

The Convener: Thank you. Clearly, these are challenging times. Does Michael Kellet want to add anything from the point of view of the IJB?

Michael Kellet (Fife Integration Joint Board): Thank you, convener. The partnership's financial position has been a challenge. However, we are absolutely focused on that challenge, working closely in partnership with colleagues in NHS Fife and Fife Council to move the partnership towards financial balance in the medium term. Carol Potter set out the position of the national health service and of the health and social care partnership very well.

The Convener: Some of what we have heard are shorter-term perspectives. What are the prospects of developing longer-term financial planning? What steps are being taken towards that, and are there any barriers to taking that forward?

Paul Hawkins (NHS Fife): We are working on a number of transformation projects—we are looking at mental health redesign and transforming acute services, and we have started to work on how we can provide faster care for patients in queues. For example, we have implemented some new cutting-edge Jack and Jill theatres in ophthalmology, meaning that consultants can walk between theatres to speed up some services. We can also do complete hip replacements in 23 hours; that treatment is now moving across Scotland for fairly healthy patients who are having their hips done. We are evolving a clinical pathways and change process; on top of that, we are trying to transform our services and working on care in the community. We have lots of long-term goals. Obviously, financial sustainability is an issue; at the same time, it is becoming more difficult to recruit consultants and other staff.

Rt Hon Tricia Marwick (NHS Fife): It is a pleasure to be here, convener.

There is a high degree of confidence in our financial position among NHS Fife board executives and non-executives. We recognise that the financial position is challenging; it has been challenging for the past two years. Notwithstanding that, we are one of the few boards in Scotland to have broken even; we did not require any brokerage from the Scottish Government to do so. Therefore, although the situation is challenging, we are confident that we have the financial strategies and plans, and that we are doing the housekeeping—that is, we have the grip and control that we need on a day-to-day basis—to ensure a high level of confidence that, when it comes to the end of the next financial year, we continue to be in a good financial position.

Emma Harper (South Scotland) (SNP): Good morning. I am interested in set-aside budgets, on which we have taken a lot of evidence from various boards. We heard that NHS Dumfries and Galloway does not call them set-aside budgets, but uses a completely different model. I am interested to hear whether you think that the set-aside budget is being managed effectively—it is fair to ask how it is being managed. Can you give us some background on that?

Carol Potter: The set-aside budget is a prevalent topic of conversation at the moment. We are working on it with Michael Kellet, colleagues in the Fife health and social care partnership, the IJB and the chief operating officer of the acute service. The transition aim, which is to move resources into the partnership, is challenging. It is early days.

In the recent submission that we provided on what we call the health and social care stock take, we said that further discussion is required. We do not have a definitive timescale for moving the budgets. Rather than having a conversation about the set-aside budgets per se, we are very much focused on the clinical model and what it means for care and the provision of patient services. When we talk about unscheduled care in the acute setting—the front door of the hospital and so on—and changing that model, it is about how that then aligns with our health and social care model. The conversation is about what the clinical model is and what gives the best quality of care and patient safety. Budget setting should follow that, but, at this point in time, the conversation with colleagues across the acute sector and with the partnership is about the clinical model, first and foremost.

Emma Harper: Is the set-aside budget controlled by the IJB and held by the NHS? Who manages it?

Carol Potter: At present, the set-aside budget is within our acute services division, so it is under the oversight of the chief operating officer. There is a range of budgets across medical specialties, accident and emergency departments and other unscheduled care areas, so it is a conversation at this point in time. The set-aside budget is very much managed and overseen by the chief operating officer, but we are moving in the direction of travel set out by the Government.

Emma Harper: Do you have timescales for moving forward?

Carol Potter: My recollection is that we will have that information later in this financial year. Perhaps the chief executive or Michael Kellet can confirm that.

The Convener: Given Emma Harper's line of questioning, could Michael Kellet confirm that information and answer the wider question about responsibility for the set-aside budget?

Michael Kellet: I am happy to do that. Carol Potter has set out the position. As the committee will know, the ministerial steering group on integration made a specific recommendation that set aside was something on which partnerships—by "partnerships", I suppose that I mean whole systems in Fife—needed to take active action and, in particular, that they needed to put arrangements in place within six months of the financial year starting. That is the timescale that we are looking at.

I understand that the Scottish Government is working with colleagues in Ayrshire on how the set-aside budget might be managed there, and the indication is that guidance and advice will be produced based on that experience. Obviously, we are looking to learn lessons from that. It is a priority for us over the first six months of this financial year.

However, as Carol Potter said, it is a challenging agenda. Given the demands on acute services, as well as the other demands on health and social care, shifting resources is a significant challenge, but it is one that we are engaging with in terms of the clinical model and making the progress that is required in light of the ministerial steering group recommendations.

Emma Harper: Okay, thanks.

The Convener: I have a brief question before I bring in Anas Sarwar. Some of the big numbers in the financial reporting are around the risk share between the IJB and the NHS board. What action is being taken in that area, particularly regarding the way in which overspends appear to be set against the IJB rather than the board?

Paul Hawkins: We are working with the council—obviously, it and the health board are the parent bodies—to look at the opportunities for reviewing the situation. At the moment, it has cost the health board a significant amount of money in terms of transferring packages to the council. In our assessment, we are hoping to look at whether we can change those percentages and work differently.

In some ways, the money follows the patient, but the difficulty is that the amount of money needed in home care packages will outstrip some of those numbers. We are trying to understand how we can work with the transformation plan in acute services to mitigate some of that as we start to go forward and work in a truly integrated way. We need to come to a conclusion on that work by the end of the year in order to move it forward.

Tricia Marwick: On the percentage share of the overspend, 72 per cent is with the health board and 28 per cent is with the council. We recognise that, if there is an overspend in the IJB, 72 per cent of that will have to be funded by the health board. Conversations are going on with the health board, the council and others to see whether our formula and the way in which the IJB was set up can be looked at once more.

The Convener: The figures show a substantial underspend in some areas—particularly community health—and overspends in others. Does that give you cause for concern?

Michael Kellet: That is the case. We are seeking to look at the budget across the whole partnership, as well as get a clear understanding of the impact of the overspend on our funding partners—the NHS, clearly, but also Fife Council. We manage the budget as a whole. There are a number of areas of underspend and a number of areas of significant overspend. We are seeking to understand all of that.

As I said, we are also seeking to plan for the long term. We set a budget for the IJB this year with an acknowledged deficit of £6.5 million, but we gave a clear undertaking to our funding partners that we would do everything that we could to bear down on that overspend in-year; we also gave an undertaking to plan earlier for future years, so that we can move towards financial balance. Therefore, the financial impact on our partners is mitigated. The IJB, the council and the NHS are doing that in partnership, and those discussions are on-going.

10:15

The Convener: Thank you. I know that Brian Whittle will come back to those questions later.

Anas Sarwar (Glasgow) (Lab): Good morning, everyone. I give a particular welcome to Tricia Marwick—it is good to see you back in the building. I have a general question. How would you rate NHS Fife's financial performance compared with that of other health boards or IJBs across the country?

Tricia Marwick: We have been very clear that the financial position needs to be balanced against our clinical performance. On how we are doing, we are one of the few boards that have not needed support or brokerage from the Government. Our performance in terms of waiting times and so on sits within the upper quartile of all the health

boards in Scotland. In terms of both finance and performance, I think that we are doing fine.

Anas Sarwar: I shall come back to brokerage in a moment. In terms of performance, whether financial or clinical, where do you see the balance in terms of economic or budgetary pressures versus workforce pressures, and how does that impact on the challenge?

Carol Potter: The two are inextricably linked. We have a number of workforce challenges in particular specialties. My colleagues—the medical director and the director of workforce—are better placed to talk about the specifics, but achieving a balance in terms of ensuring that we have the right staff in the right place for the right patient groups sometimes comes at a cost. We obviously have supplementary staffing costs, but we are trying to look at innovative ways of supporting a workforce model that sits comfortably alongside the financial position.

For example, we have a very effective relationship with colleagues in Lothian around radiology. There is a shortage of radiologists not just across Fife but across Scotland and the United Kingdom in general. Through a technology solution that allowed colleagues in Lothian and Borders to report on images from Fife, we have been able to put a mechanism in place. It delivered on our qualitative and operational performance in terms of reporting on images; at the same time, it helped us find a solution to a workforce problem and came at a lower cost than the significant rates that supplementary staffing would cost.

Anas Sarwar: Do we need to see more working across health boards to try to share capacity and resource?

Carol Potter: Absolutely. It is about finding innovative solutions, via technology or other ways of working, that support our financial position as well as our workforce.

Anas Sarwar: I want to pick up on two points that Tricia Marwick made. The first relates to an earlier answer that she gave on how the IJB was set up and how perhaps that needs to be looked at. Are any particular reforms being considered, and are there any lessons that can perhaps be learned across the rest of the country?

Tricia Marwick: The IJB has been in place for three years now. In respect of the formulas, including the funding formula, and the way it worked from the beginning, all the partners in the IJB need to have those conversations and look at whether they are doing the best that they can. Such conversations are taking place, because we need to ensure that the IJB reaches a good financial position and that we can give our patients the care that they need.

Anas Sarwar: If that partnership is going to work, does it not require a properly funded national health service and properly funded local government?

Tricia Marwick: You are asking me to indulge in politics.

Anas Sarwar: You would never do that, of course.

Tricia Marwick: I would never do that—certainly not in this role or in my previous role.

Of course, we need proper funding, but at the moment NHS Fife is doing okay with the funding that it has, although we could always do more.

Anas Sarwar: This may be a final question; I suppose that it depends on what you say. You have good financial performance, so you do not ask for a bail-out and you do not get brokerage, whereas other health boards get brokerage, which is then written off. How does that make you feel?

Tricia Marwick: I do not think that it will come as any surprise that I was miffed. We have worked very hard in Fife to ensure that our financial performance has been the best that it can be, and it is frustrating that some of the decisions that we have made, with the fantastic support of our staff, have perhaps meant that there are other things—do not ask me what they are—that we could have done if we had gone into financial—

Anas Sarwar: Do you mean that it feels like bad behaviour is rewarded?

Tricia Marwick: Mr Sarwar, I will not allow you to put words in my mouth. I will say that it is a matter of great pride in Fife that we have managed to break even. I would certainly have liked more money, just as some other health boards got more money, perhaps through brokerage. I would have liked to have seen some sort of recognition of the fact that we are doing fine.

Emma Harper: I am interested in hospital-acquired infections. Your submission says that you have “exceeded” the C difficile targets, which is great. I am a former clinical nurse educator who used to teach central line infection and cannula-related best practice and management. I am looking at Dr Chris McKenna as somebody who might be able to answer this question. What steps has the board taken to ensure that NHS Fife reduces the number of hospital-acquired infections—the staphylococcus aureus bacteraemias—to achieve your rate of 0.24 per 1,000 acute occupied beds?

Chris McKenna (NHS Fife): We are taking a multiprofessional approach to reducing hospital-acquired infections. As you said, first, we are one of the best hospitals in Scotland for the reduction in C diff infections in NHS Fife. That has been a

fantastic achievement through multiprofessional working with our infection control colleagues and our microbiology team, and through good antimicrobial stewardship. That has been a fantastic success for us. Staph aureus bacteraemias remain a challenge for all health boards. We have a multiprofessional vascular access group looking at how we manage, care for and document vascular access devices.

We have done focused pieces of improvement work in certain parts of the hospital where we recognised that improvement was required, such as in our cardiology unit and our renal unit; those pieces of work are now looked upon nationally as areas of excellence and for learning. By taking the approach of learning from events in a systematic way, we are able to introduce stepwise improvements into our services to ensure that we can reduce those infections.

One of the innovative ways in which we are able to ensure effective governance around the insertion of peripheral cannulas is with the use of our electronic documentation for each of those devices. NHS Fife is the only health board in Scotland that has Patientrack, which we call our electronic FEWS—Fife early warning system. It provides an early warning score that is documented on iPads and available to anybody at any point across the hospital. We now document the insertion of cannulas on that system as well, which generates alerts and reminders, such that medical and nursing staff know when cannulas need to be reviewed and when they need to be changed. That has led to significant improvements across our organisation.

Staph aureus bacteraemias remain a large focus for us. A challenge remains around community-acquired infections. These are infections with the staph aureus bacteria that are brought into the hospital by patients from the community. They are multifactorial and thus the improvement plan around addressing such infections is much harder to implement. They may be infections of patients with diabetes or fairly random skin infections.

The other part of the issue concerns those members of our community who inject drugs. That remains a challenge for us. We are looking at how we work with that group of patients to try to reduce their risk of infection. We are working with our addiction services to understand how we can better influence that group of patients to reduce their risk. We have a multifocused, multifaceted strategy for reducing hospital-acquired infections. We are also going beyond that for SABS, to reduce the total rate.

Emma Harper: There is in-hospital infection and out-of-hospital infection, and the community-acquired infections are not necessarily caused by a person's cannula or other line being contaminated by a healthcare professional. If we peeled apart the numbers, we might be able to see that the hospital-acquired infections are not necessarily hospital-acquired but could have been acquired by patients in the community.

Chris McKenna: Yes. Some of those infections will be in patients who present to hospital with a condition, who are unwell, and who subsequently turn out to have a staph aureus bacteraemia. However, that might not be hospital-acquired or device-acquired; it might be related to random infection or infection as a result of a pressure sore, an ulcer or something like that that has gone into deep-seated infection.

The Convener: None of that explains why your performance is poorer than the Scottish average.

Chris McKenna: Our performance has improved significantly over the course of the past five years. The total number of staph aureus bacteraemias is higher than the Scottish average, but that is complicated by a higher number of patients who are coming into our organisation with infections. We recognise that there is still work to be done with our hospital-acquired infection. We are working on that.

Miles Briggs (Lothian) (Con): Good morning, panel. I want to focus on performance around mental health waiting times, specifically with regard to child and adolescent mental health services. The current performance of NHS Fife is at 74.1 per cent against the national target and I wonder why performance has worsened over 2019.

Michael Kellet: I will take that question. Mental health and CAMHS is a function that is delegated to the IJB. Improving our performance in CAMHS has been a real priority for us over the past number of years. Our performance in 2018-19, at 76 per cent, was almost 10 per cent higher than it was in 2017-18. Before we came this morning, I checked the latest performance figure: in March it was at 80 per cent. The figure moves about slightly but we are pleased that, overall, the trajectory over the past couple of years has been improving. That has been the result of a real focus on CAMHS performance within the board and the IJB. Also, we have increased investment and the number of clinical sessions in specialist CAMHS by 15 sessions a week, particularly to target those children and young people with the longest waits.

The other significant development that we are endeavouring to pursue is a broad-based approach across all services. We are working in partnership with colleagues in Fife Council who are responsible for education, as well as with the third sector. We have developed a strategy called our minds matter, which focuses on supporting children and young people at an early stage, in

school or in the community, when they are expecting distress or challenges around mental health and wellbeing. We are seeing real results on that. We are investing in supporting the training of school guidance teachers, school nurses and other staff in schools and in the community.

We have also used Government resources under action 15 of the mental health strategy to invest in primary mental health workers—one in each of the seven sub-localities in Fife—which means that, as of 1 April this year, when a general practitioner refers a child or young person, they will be seen within one working week. That primary mental health worker will either support the child or young person themselves, refer them on to a voluntary sector provision, or, if it is required, make sure that they are referred as quickly as possible to specialist CAMHS. The advantage of that approach is that, for the first time in many years, we are now seeing a slight reduction—although it is only a slight reduction—in the monthly referrals for CAMHS because, we believe, we are supporting children and young people earlier in universal settings and other settings in the community. It has been a real focus for us. We have further to go—we are not at the target yet—but we believe we are moving in the right direction.

10:30

Miles Briggs: In some of the inquiry work that we have done in the past, we have heard from parents from Fife who have outlined their concerns about access to services, especially for children who are self-harming, which was one of the key issues that were highlighted to the committee. It sounds like you have already been undertaking some change in the area of outcomes from mental health services, but how do you measure outcomes as someone goes through the health service as well?

Michael Kellet: We need to track those cases on an individual basis. You are right: the CAMHS target is important, but it is only one measure of the efficacy of the services. We need to look at how those services are supporting individual young people. I know from speaking to the team that they take that very seriously. The other thing that we do, even within specialist CAMHS, is make sure that children and young people in urgent need are seen very quickly. In urgent cases the target is that people are seen within two weeks, and we endeavour to make sure that that happens where at all possible. We need to track outcomes across the board, and the team do that. They seek feedback from families and carers themselves. We recognise that we have more to do on capturing the views of the children, young people and families whom we serve. That is a focus for the team moving forward.

Miles Briggs: One of the key questions that I have been asking health boards as they have come to do this kind of MOT is what sort of culture they have built for their staff around mental health. I know that you have high sickness absence rates compared with other health boards, so I wonder what the current picture of mental health support for NHS Fife staff is like.

Barbara Anne Nelson (NHS Fife): As you would expect, there are multiple facets of workforce mental health support for the board to consider as an employer, so we are undertaking a number of workstreams in relation to that. Obviously, one of the main reasons for our sickness rate is mental health issues. We have introduced an element of mental health training into our joint promoting attendance training that we do in partnership with our staff-side representatives. We currently have a gold healthy working lives award. Part of that is to do with assessing what we give to our workforce in the area of mental health support. We are looking to go beyond gold. We secured investment for supplying mindfulness training and good conversations training for our staff. One of the benefits we are getting from that—we have had very positive feedback—is that staff are looking to use it not only in the sense of the clinical placing when they are at work but outside of work.

The other thing that we want to look at is whether we can increase, in any way that we can, the support that we give to our staff on mental health issues. We know, from the work that we have done with staff, that many of the mental health issues that our staff experience are not work related but relate to life events outside of work. We are looking to see how we can broaden potential input from external support to give our staff other options to allow them to remain at work. We have also introduced a very quick referral system with our occupational health service. We are continuing to develop awareness in our managers, and in our staff; if they see colleagues struggling, they should help them. It is not only the managerial aspect; there is a colleague part as well. We are looking holistically at mental health in our workforce—not just policies and practices, but beyond that. As I said, we have a number of workstreams looking at that in partnership with our staff-side colleagues on the board.

Miles Briggs: You said there was external support. What does that look like? I know that NHS Lanarkshire is using a company that provides not only assistance around mental health but financial support for lower-paid NHS staff who have financial difficulties. Do you already have that in place?

You spoke about very fast referral. What is that? Is that the next day or are we talking two weeks?

Barbara Anne Nelson: I will take the fast referral point first. Because ours is an internal occupational health service, if someone really needs an urgent appointment we can arrange that with our occupational health staff. If they are not able to provide an urgent appointment, we can secure occupational health support from neighbouring boards. There is that collaborative element with other boards if we are unable to meet that need.

As for external financial support for staff, we have a credit union in place, introduced in partnership with our staff-side colleagues, which was very successfully received. We are also looking to see whether we could bring Citizens Advice Scotland on site to broaden the on-site support for staff. We are at the very early stages of looking at that.

The Convener: I have a question for Michael Kellet. The primary care transformation fund and the primary care mental health fund have been established by the Scottish Government to assist in precisely these areas. How have they been used, and what impact have they had, or do you expect them to have, on demand for specialist mental health services?

Michael Kellet: I will take each question in turn. We have avidly pursued action 15 money to pay for Fife's share of the 800 extra mental health workers in Scotland and are on target to deliver that share. There has been a particular focus on supporting children and young people. The primary mental health workers whom I talked about, who support CAMHS, are part of that, but we are also investing in mental health support for GP practices more generally for the wider population.

We are also thinking about how we can support A and E and ensure that people presenting at A and E with mental health crises can be supported. One example is that, working with the Scottish Association for Mental Health and the voluntary sector in Fife, we recently opened SAM's cafe, which is open during twilight hours—2 pm until 10 pm—from Wednesday to Sunday. It is a place where people with mental health distress can be taken that is an alternative to police custody or A and E. A peer-based approach is working there. It is very early days—it has been open only for a month or two—but we are seeing good results there and it has been well received.

In terms of the primary care transformation fund, we are working hard with GP practices across Fife to agree the primary care improvement plan. Only last week, at our IJB meeting on Friday, we agreed year 2 of the plan and what the investment will look like. We have made good progress. For example, we have invested in a phlebotomy service for all GP practices across Fife. We think that we are the first board or IJB in Scotland to have a comprehensive phlebotomy service funded through the primary care transformation fund. We are also concentrating on pharmacotherapy, so that pharmacy support for GP practices is well supported by the fund as a priority.

We are pleased with the progress that we have made. Clearly, as more funding comes from the primary care transformation fund year on year, we will be able to invest more in the multidisciplinary team approach in GP practices. We have made good progress and are focused on maintaining that progress as we move forward.

The Convener: There are 90 per cent targets for referral to treatment for both CAMHS and psychological therapies. When do you expect to be in a position to meet those targets?

Michael Kellet: Psychological therapies are more of a challenge for us than CAMHS has been, not because we have not focused on it but because our performance there is not as good as it should be and we recognise the need to improve. On that front, we are redesigning the service to better meet the range of needs that present. We are making good progress in supporting people with less complex needs through group therapy, community mental health teams and information technology support.

Moving forward, our particular focus is on how we improve performance for adults with more complex needs. That has been a real focus for us. We are working closely with the combined mental health access improvement team that the Information Services Division and Healthcare Improvement Scotland have in place. They are supporting us in that redesign. Our trajectory is set out in the annual operational plan. We are quite clear that we are making faster progress in CAMHS than in psychological therapies, but we are focused on making progress on both.

Sandra White (Glasgow Kelvin) (SNP): Good morning, panel. I welcome Tricia Marwick. As Anas Sarwar said, it is good to see you on the other side of the fence, as it were.

I want to pick up on what Miles Briggs said about sickness absence. I know that it was worse in 2017-18 than it is now. You have made a slight improvement, but Audit Scotland said:

> "There is a risk that sickness absence will remain at a high level and impact on staff morale, quality of care, and the achievement of statutory performance targets".

In reply to Miles Briggs, you mentioned the actions that have been taken, such as on

mindfulness and occupational health services. Why is sickness absence so high in your board?

Barbara Anne Nelson: There are a number of factors. It is a bit like a jigsaw: a whole number of things can contribute to it. We need to look across the piece. It can be a range of things. We look at and critically examine our short-term and long-term statistics. Our absence performance is discussed every month at our area partnership forum and our staff governance committee, so there is a lot of discussion and scrutiny of our performance in that area.

We have looked at doing a deep dive through surveys in certain areas. We have looked at discussing with our older workforce whether there are specific issues that contribute to sickness absence. We have regular discussions with staff about whether there are any specific problems in certain areas. We can look at data from different areas and begin to see whether there are any particular hotspots. That allows us to have a more specific discussion, such as on whether sickness absence is anything to do with a particular workforce or working environment.

Again, we have to look regularly across the piece, so it is difficult to give one answer. A number of factors contribute to the issue. In Fife, as I said, a good number of workstreams are being taken forward in partnership with the staff side, which wants to work with us on making Fife the best place to work in and on how we can support people back to work quicker. We have a number of supportive policies. We want to ensure that they are being used to the full to allow staff to come back to work more quickly and more flexibly. We have lots of good examples of that.

I give you the assurance that we look at sickness absence on a monthly basis and across the year, when we get our end-of-year figures. We know that it remains a challenge and that it is a challenge for a number of boards.

We must keep that dialogue and discussion going to get to the bottom of what we as the employer can do to assist staff to remain at work. I mentioned earlier awareness of mental health issues and earlier support, as well as colleagues looking to staff and helping them. There is a cultural aspect of supporting colleagues at work.

We are looking at every element of the issue to see what we can do to improve our performance. We have just started running a series of workshops, and we are getting direct feedback from managers, supervisors and staff about how promoting attendance feels for them generally, not just regarding the application of policy. We ask what message staff want to feed back to us as the employer on what they think would help. Again, those workshops have been received very positively. We will run more workshops throughout the year alongside all the other multigenerational work that we do, particularly on whether we can offer support for issues in certain areas.

A huge number of things are happening to allow us to get to the bottom of sickness absence. We have a very positive approach; as I said, the mindfulness and good conversations training are beginning to have an impact in terms of understanding what issues look like and helping managers have conversations with staff who may be having difficulties, even if they are not in work. We are running a number of different work strands to get to the bottom of the issue and improve our performance.

10:45

Sandra White: Could something as simple as transport be part of the problem? I had a meeting with staff at Glasgow royal infirmary just the other day, and transport, particularly parking and parking charges, was raised as a huge issue. People might have transport issues when trying to get into work, leaving late, working at weekends or whatever it may be.

Barbara Anne Nelson: It may be part of the problem. That is why I am saying that we need to look beyond the issues that are just within the work environment that we can control. Some of the issue may be related to that, or it may be the temporary impact on staff of something that has happened in their family life, which we might be able to be flexible about and help them with.

I think that you are right: there are a number of other things that may not be directly related to the workplace, although they could be. There may be financial issues or illness within the family, for example. We can use some of our policies to help staff in such situations, but we want to have a broader discussion and see whether we can provide broader support, perhaps outwith work-related things, so that we can help staff.

Sandra White: You mentioned conversations. Are the staff consulted? How do you have the conversation with staff about why they cannot get to work, the sickness or the reason for the absence? Is it a tick-box exercise in that respect?

Barbara Anne Nelson: I would hope not. There are a number of ways in which that conversation with staff happens. You can have a very formal conversation with a member of staff when they return to work as part of the policy. That should not just be about the return to work after the absence; it gives the opportunity for a broader discussion about other things that the person may want to raise.

Outwith that, normal management conversations with staff also give the opportunity to have those discussions. That is where the good conversations training that we ran last year and are looking to continue this year comes in. Some of these topics are quite sensitive for staff to come forward and speak about. That good conversations training equips people to have those conversations in a very sensitive and supportive way. We would hope that the kinds of normal management relationships that people have with colleagues help them to be confident in raising those issues.

Sandra White: If we could get to the nub of that issue, what is the financial cost of sickness absence to the board? Do you take that into account?

Barbara Anne Nelson: In the reports that we provide on absence, we can look at what that means in terms of a financial figure. It must be taken with a health warning, because in calculating the true cost of absence—I think that my director of finance would agree—you have to look at a number of factors. Yes, for us there is a cost aspect and lost productivity, but the more important question is how we help our staff to stay at work and support them so that they do not go off, or how we get them back more quickly.

We must recognise that sickness absence has an impact. The question, however, is how we support our staff at work, how we help them be off for a shorter period, how we get them back more quickly or how we keep them in a situation where they may not need to be absent at all, if we are able to intervene more quickly.

The Convener: More broadly, it was very concerning to see the fall in participation in the iMatter staff survey. I think the participation in Fife is now so low that you do not have any official returns for last year. Is there a reason why that situation has arisen?

Barbara Anne Nelson: There is research that shows that, once you are into your second and third iMatter cycles, there can be a drop in participation. I am pleased to report that in the iMatter cycle that we are in now, we have increased our participation level and the board will receive a report that will allow us to look at the issues that iMatter covers and develop an action plan in respect of them.

Outwith that, though, I assure the committee that in the year in which there was no report, that did not mean that we could not consider why we did not have the report and ensure that the issues were picked up on. Although there was no board report, we considered why that had happened. It also allowed us to encourage managers to re-energise engagement with staff. The recent return has proven that that has happened, and the reports are out just this week.

Sandra White: Dementia referrals is an area that interests me. Obviously, there is information on referrals from the health and social care partnership.

The number of patients waiting for contact from a link worker rose sharply in the last quarter of 2018. Can you give the number of patients waiting for contact from a dementia worker and explain why it rose so sharply in 2018? What is the current situation with the waiting list for dementia posts and diagnostic support?

Michael Kellet: I will deal with that. That figure came up at the IJB's finance and performance committee just last week, and we had some detailed discussion about it. We are not sure that the figure on the increase in waits between referrals for post-diagnostic support and contact with a link worker is accurate; we think that it could be a result of recording. Coming out of that discussion with the finance and performance committee, we agreed to look at the issue as a matter of urgency. It has not been an area of challenge for us in the past, and we do not really understand why it is now, so we are seeking to get underneath that.

Targets for post-diagnostic dementia support are a real focus for us in Fife, but we also have what I describe as a broad campaign on making Fife a dementia-friendly community. In Glenrothes, we have the first dementia-friendly community, and we are investing in and supporting other communities to come on board. Only in the past couple of weeks, I was at an event at which we recognised that around 150 businesses and organisations across Fife—everything from chip shops and bowling clubs to big commercial businesses, supermarkets and others in between—have put their staff through dementia-friendly training. We also have more than 4,000 individuals who have gone through that training.

Building awareness of and tackling the stigma around dementia is a real focus for us, as is ensuring that individuals who are diagnosed and their families get that support. If it would be helpful, I would be very happy to write to the member when we have a detailed understanding of that figure, because at the moment we are not convinced that it is accurate.

The Convener: If you would write to the committee with that information, that would be helpful.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning to the panel. Welcome to the Rt Hon Tricia Marwick—it is good to see you again. I would like to take the discussion back to organisational health and staff morale. One of the

determinants of staff morale is how staff feel supported, how safe they feel and how they feel their concerns will be dealt with if they are raised. How many whistleblowing complaints is NHS Fife currently dealing with?

Barbara Anne Nelson: This year, we have received one identifiable whistleblowing case that has come to the chief executive of the board. We are currently looking at how we can strengthen the way in which we get data on whistleblowing throughout the organisation. Any whistleblowing case that is received tends to be escalated so that we know about it. In 2019-20, we have had one formal case.

Alex Cole-Hamilton: That seems quite low for one of the biggest territorial health boards in the country. How does that compare with previous years?

Barbara Anne Nelson: We had five last year. We know that from our collation of the data, but we also have the national reporting line that was set up for NHS Scotland. The provider of that has changed, but in the reports from the previous provider, our figure always sat at zero to three—that could be anything from zero to three, as we never got the detail—apart from the one year in which we received more than that. The figure has always been low. This year, we have one case being dealt with formally.

Alex Cole-Hamilton: I will ask about the organisational health at the top of the organisation. You have had quite a lot of churn of board members and members of senior management in the past 12 to 18 months. For example, your former chief operating officer, Scott McLean, left last summer and it was not entirely clear why. What were the reasons for his departure?

Paul Hawkins: The reason for his departure was that he resigned from the board.

Alex Cole-Hamilton: On what grounds? What precipitated his decision to resign?

Paul Hawkins: He made a decision to resign and take up another post somewhere else.

Alex Cole-Hamilton: Some of the background noise around the churn at the top of the organisation has led to suggestions of bullying. How would you respond to those?

Paul Hawkins: I do not believe that there is bullying in the organisation. When we hear of any issues to do with bullying, we clearly deal with them immediately and investigate them. Whether they come through whistleblowing or the normal way of managers working through things, we pick them up and deal with them through the human resources channels and the other systems that are there. We will also work through them in partnership.

Alex Cole-Hamilton: You are confident that staff at every level of the organisation, if they felt bullied, sidelined or marginalised, would know who to speak to in the organisation. That can be quite difficult if they do not feel that they are being listened to at the top of the organisation and if they do not have faith in the organisation's leadership. Who do they raise those concerns with?

Paul Hawkins: We have done significant work with individuals so that they understand that their line manager is the key person to go to. Obviously, if the line manager is a problem, they have other people they can go to as well. We do that in partnership with the staff side to make sure that that information is freely available. We have very open conversations with the staff side about how we can support staff with these issues.

Tricia Marwick: When you talk about a churn of senior staff, you are right. We have lost a number of senior staff recently, most of whom have retired. We have recruited equally wonderful people in their stead; we have a new director of public health and a very new medical director. That is part of the churn. Senior staff are part of the churn and we are recruiting.

Alex Cole-Hamilton: You seem to have more churn among board directors than other health boards do. Is that just happenstance?

Tricia Marwick: It is partly to do with our age profile. Two senior members of the board have retired.

Paul Hawkins: As we are a medium-sized board, there are always opportunities in bigger tertiary boards or other things that directors want to do. Directors get to director level at an earlier age now and they want to have a portfolio career and to do different things. With no disrespect to him, I say that Chris McKenna is a very young medical director and may want to do other things in his career before he retires. We are in a different world and much more mobile directorships are going on across Scotland and the UK.

Tricia Marwick: Sadly, our director of performance left us and she is now the chief executive of the Golden Jubilee hospital. That is the point that Paul Hawkins is making. Opportunities come up, and part of our role as leaders of the organisation is to give people support, mentoring and confidence so that, if they wish to take up other positions, they go with our good wishes. We hope that we can entice them back at some point in the future, but we cannot stop it. Scotland is a small place. Fife is a relatively small board area, so when there are opportunities, people will go. However, we have also had an age profile that has led to two senior directors retiring.

Alex Cole-Hamilton: I will follow up with a question on a completely different issue. Why are your waiting times for urology some of the highest in the country?

Paul Hawkins: We have had problems recruiting urologists. We work closely with Lothian on our cancer work, using the robots. We have managed to recruit a new urologist who is coming through now, so urology is a critical area of pressure on the system for us. It is a critical area nationally as well. We are looking at different ways of dealing with some of the urology patients. We are very lucky to have one of our urologists working with something called UroLift, which is a different way of dealing with patients with prostate issues that are precancerous. That means that we can do those works in a treatment room and get some of the bigger operations through the system, not using theatres and beds or requiring a stay in hospital. We are trying to innovate at the same time as trying to recruit. Ultimately, the strategy around that is to link up with Tayside and Lothian and have shared sessions, with consultants working in both so that we can recruit some of the higher-level work that can be done in Lothian and see some of the district general work that we are doing as part of that plan.

Alex Cole-Hamilton: Do you have a time window in which you expect to see improvement roll out?

Paul Hawkins: I hope that, by the end of the year, we will be able to recruit some more urologists by doing that practice with Lothian. However, sometimes what you end up with is a churn, in that somebody retires and you manage to recruit someone simultaneously. Urology is a key area in Fife as well as Lothian, and we are working with NHS Lothian.

11:00

Tricia Marwick: The board has been quite innovative and very successful in recruiting specialists and nurses. We are overrecruiting at the moment. We have recruitment boards in which everyone who is above the line will be offered a job. That means that we will make sure they have a job so that, when a vacancy comes up, we do not have to recruit again. Barbara Anne Nelson and Helen Buchanan, our nurse director, who is not here, have done a fantastic job in recruiting nurses.

Barbara Anne Nelson: This year, more than 200 nurses will be recruited into NHS Fife. At a challenging time for us and other boards—we are all facing workforce challenges—that is impressive. That is the result of the very proactive work that my nurse director and our colleagues do with the universities. They have also had successful discussions on the reintroduction of training and placements in Fife for specialties such as mental health, which previously had not been the case. There is a lot of positive work happening in Fife on nurse recruitment.

Chris McKenna: I just wanted to add to the urology conversation, because it is important that we recognise that the pathway for management of urology cancers, in particular prostate cancer, has changed and is significantly more complex and, as a result, cross-health board. Not all the treatments that would be delivered for one patient would be delivered in Fife. Part of the pathway may be in Fife and part of it in Lothian. That is where complexities around waiting times arise. One of the aspects of the urology pathway that Fife does fantastically is access to MRI. In spite of our challenges around radiology, access to MRI scans and reporting of the scan in Fife is among the best in Scotland. It is a complex issue but, as Paul Hawkins said, we are working with our local team and the multiprofessional team across Fife and Lothian to improve and streamline that pathway. It is a work in progress.

Paul Hawkins: Overrecruiting sounds a little mad, but it is not because, as we have overrecruited, we have minimised some of the agency use and bank use of consultant staff. As the churn happens, we have somebody to walk into the vacated post. That improves quality, reduces cost and gives a sense to the organisation that we are listening to it about the pressures that are in the system.

Brian Whittle (South Scotland) (Con): Good morning to the panel. My interest lies in the integration of health and social care. I notice from the 2019-20 budget that, as I think the convener alluded to, a net budget gap is predicted of just north of £6.5 million. How do you intend to close that projected gap?

Michael Kellet: That is a focus for us. We have recognised that we have to plan for both the short term and the long term, and we are doing that in partnership with our partners. Last week, we had the first of a number of sessions with a broad-based management team across the health and social care partnership. We had a dual focus on how we can bear down on the £6.5 million overspend this year, take out more efficiencies and cut our cloth to make sure we deliver on that and push the figure down; as well as on how we can look to the longer term, recognising that that means redesign and that we will not achieve financial balance through efficiencies—that we need to redesign ourselves and change how we deliver what we do. We need an emphasis on early intervention and prevention. We have begun to do that, but we recognise that we need to do more on that.

We need to support people to support themselves and to be supported in their communities. On the work that we are doing in localities, we have a network of wells—a new one-stop shop for support for people with health and social care needs—right across Fife. That is the approach. We are taking focused action, but we are also investing in early intervention and prevention, recognising that if we do not change the shape of our services, our ambition to deliver financial sustainability will be very hard to reach.

Brian Whittle: On that point, I note that there is an underspend, which again has been mentioned, in community services. You talked about early intervention and prevention, which would suggest that the shift towards community is where most of that redesign is likely to be. Can you explain that underspend in community services and say how you will address it?

Michael Kellet: I am happy to do that. The significant underspend that we had last year was in our community healthcare budget—I think that it was just north of £4 million. That was largely around vacancies in community nursing, general dental services and administrative support. The underspend in the community healthcare budget is something that we will keep an eye on.

Clearly, we do not want to be in the position of not having community nursing posts filled, but the new developments in the preventive space that I talked about are intended to support people before they need or require statutory services. It is about how we can connect people with third sector organisations and help them to support themselves. The network of wells is beginning to do that. We have seen innovative practice to support people to support themselves. There is an active well in the town centre in Kirkcaldy that is open for a number of hours a week. It is doing innovative things to support individuals who are isolated to come together in the local Costa across the way in the town centre. They are innovative means of connecting people who would otherwise be isolated and trying to build support creatively. That is one example of how we are trying to ensure that we are in the preventive space.

Brian Whittle: Just to push a little further on prevention, where are you on adoption of technology? I imagine that technology can play a big part in the shift from secondary to primary care and into the community. Where are we on that sort of adoption?

Michael Kellet: It does, and we make lots of use of technology. We have a very extensive network of community alarms across Fife. We also have telehealth and telecare, which support a large number of individuals. It is an area of focus for us. We are just in the process of revising the strategic plan for the health and social care partnership. One of the priorities that we identify in that is that we need to make a step change in our use of technology so that we can deliver services differently. Innovation is happening. Snap40, a device that can monitor people's vital signs effectively, is being piloted in our hospital-at-home service. We are also looking at other examples of working with a company that has developed an app that supports and prompts people living at home who need a reminder to take medicines. There are a number of approaches here, but one of the things that we said in the strategic plan is that we need to focus on improving that digital agenda. We are working with the e-health and IT leads in Fife Council and NHS Fife to help us on that agenda. We are doing a lot, but there is certainly more to do on the digital front.

Brian Whittle: Thank you. I want to give you the opportunity to respond to Audit Scotland, which is suggesting that the health and social care regimes in Fife may not be operating as effectively as they could. One of the interesting things that it notes is that

"Staff and members are sometimes predisposed towards the interests of their employing organisation rather than the partnership".

That is not an unusual position; it is one that we have heard in other IJBs. I want to give you an opportunity to reply to that and let us know how far along that integrated pathway you are.

Tricia Marwick: We have eight members from the health board in the health and social care partnership. On behalf of the health board and myself, I can say that the health board does not tell them what to do. The legislation is quite clear that, although they may be members of the health board, they are there in their own right. They never go to the IJB with a mandate from the health board. They know, of course, what the issues are. They have to make up their own minds and make their own decisions about them, but there is certainly not pressure either from me or from the health board for a particular outcome.

Michael Kellet: To build on what Tricia Marwick said, there are eight voting members on the IJB from the health board and eight councillors from Fife Council. What I see is an increasing willingness among those members to come together to try to understand issues in a private space, and to spend time together identifying the key issues for the partnership. The ministerial steering group reviews their recommendations.

The self-assessment that we had to do in Fife was quite helpful, allowing us to come together across the system to look at the priorities. Interestingly, we brought those 16 voting members together informally last week, at their suggestion and that of the chair and vice-chair of the IJB, to develop that sense of togetherness and shared

endeavour. From my perspective, that feels as though it is making progress. I know that both the chair and vice-chair of the IJB are determined that that approach will continue. They will continue building that culture, recognising that, for both bodies, the voting members on the IJB are aware of the pressures on their constituent organisations but also that, when they are around the IJB table, they need to come together to make decisions in the best interests of the people of Fife. I think that we are making good progress in that regard.

The Convener: Am I to take it from the contributions of both Tricia Marwick and Michael Kellet that you accept the view of Audit Scotland that more needs to be done in this field?

Tricia Marwick: I certainly accept the view of Audit Scotland, and that view is reflected around the IJB table. It is the view that I get from the members of the health board who are on the IJB. Everybody recognises that more work needs to be done. It is a pretty new organisation—it is only three years old—and the two cultures of the council and the health board must be melded together. I think it is fair to say that they are probably not there yet. Nevertheless, I have seen that, as Michael says, progress has been made and there is a great willingness to work as best they can for the good of the people of Fife.

Michael Kellet: I agree with what Tricia Marwick says. It is fair to say that there is more to do—everybody around the IJB table would recognise that—but progress has been made.

Paul Hawkins: I confirm what the chair just said. It is a three-year-old organisation that has shown maturity but needs to mature further to understand exactly what it is there for and how we should move forward on some of the deliverables. That needs to happen at speed now, as with some of the finances, too. I think that a good future is coming. Putting health and the council together is the only way forward; the question is how we make it work. Although there are continual changes, with different people sitting on the IJB as politicians move and non-executives change, we have to keep the brand and move forward with integration.

Chris McKenna: As the only voting member on the IJB sitting here today, and as a new member of that group, I think there is extreme willingness to learn and grow together to develop the relationships. That is what I have found, and I think it is reassuring. There are difficult aspects to bringing the governance of care and health together in one place. I can see the challenges that that brings, but there is a willingness around the table to manage those challenges professionally and productively, which is positive.

11:15

Tricia Marwick: In Fife, we are fortunate that we have one council, one health board and one IJB. That is not the situation in most parts of the country, where there are five or six IJBs per council. We are in a really lucky position, but with that comes responsibility. We want to make the relationship work and we know that it can work, because, if it does not work in Fife, with all the advantages that we have, it is not going to work anywhere. Everybody in Fife—the health board, the council and the people who run the IJB—is absolutely committed to making sure that it works for the benefit of the people of Fife.

Paul is right: bringing together certain aspects of the health board and certain aspects of the council is the right thing to do. We need to make sure that the transformational change that we all recognise needs to happen now happens apace, but it is important that we take people with us. If there have been problems, they are about the two different cultures. As the organisation beds down, the problems will be lessened.

The Convener: Thanks for that. It is an interesting perspective. Some of what we are hearing today is what we have heard from other IJBs and health boards earlier in the process. It seems that, despite the coterminosity, you are behind the pace in some ways in achieving that change. I am sure that we will reflect on that.

David Torrance (Kirkcaldy) (SNP): Can you explain why there has been an increase in delayed discharges and what measures the IJB is putting in place to sustain improvements in that area?

Michael Kellet: Delayed discharge remains a real focus for us in the health and social care partnership, working very closely alongside colleagues in the acute hospital. You are right that the figures have increased recently. However, if you look at the position over the past few years, you will see that we have succeeded in reducing the overall number of delayed discharges in the system as well as the number of long delays. Nevertheless, as I have said, challenges remain. I looked at the total number of delays in our system, because I thought that the issue would come up today, and it was at 68 yesterday. That is higher than we would like, but it is an improvement on the position that we saw over the winter.

The way in which we tackle delays is multifaceted. Our discharge hub, which is located in the Victoria hospital in Kirkcaldy, is run by a team from the health and social care partnership that I have responsibility for. It is a multiprofessional team with social workers, health staff and others whose daily focus is on working with the acute hospital to ensure that we have flow across the system. It ensures both that there are

discharges to social care and that we discharge people efficiently from the acute hospital to one of our community hospitals when that is clinically required for them.

The discharge hub has evolved over time, and we see it as a real source of strength and innovation. We have worked with Shelter on how we support homeless people who come into the hospital system. We also have a particular project around how we support military veterans, working with the defence medical services. It will remain a constant focus for us, but it is a joint endeavour between us and acute colleagues. It is something on which we focus daily. Senior managers are involved in a weekly meeting on performance, and we have a system of escalation to bring things to my attention and, ultimately, to Paul's, if that is required and if delays are not moving in the right direction. We have made significant progress, but we recognise that there is always more to do.

David Torrance: How much is the current level of delayed discharge costing?

Michael Kellet: I do not have a figure immediately to hand for the 68 beds, I am sorry to say, but we can certainly get that figure. We have figures for the number of bed days that were lost in 2017-18. The Scottish average was that 7.8 per cent of bed days were lost because of delayed discharge, and the Fife figure was 7.5 per cent, which was just below the Scottish average. I do not have the cost figure immediately to hand, but I can certainly supply it.

David Torrance: In previous evidence, the committee has heard that the supply of care home places has affected delayed discharge. What actions are you taking to alleviate that problem?

Michael Kellet: The availability of care home places is not a significant challenge for us in Fife. We have approximately 3,000 care home beds across the kingdom, about 10 per cent of which are in council-owned care homes. Thankfully, our trajectory is that we are making less use of residential care than we have previously, which is in line with our ambition to support more people at home or close to home. The biggest challenge that we face in dealing with delays is our capacity—both in our in-house service and in independent providers—to support people with care in their own homes. We are working on that.

We have innovated in that regard. We introduced a system called Totalmobile, first in our in-house service, which has made scheduling much more efficient and means that we can make sure that we are running as efficient a service as possible. That service is now being extended to the independent and voluntary sector, where we expect to see the same improvements in performance. We also work closely with the providers to encourage them to develop their services. In Fife, we work with 27 providers of care-at-home services in the independent or private sector. I have a team that liaises with them closely about improving their capacity to meet the market needs.

We have challenges in particular areas. As you might imagine, we have a challenge in recruiting care-at-home staff in north-east Fife. Interestingly, we have a particular challenge at the moment in the Cowdenbeath area as well. Again, we are working with providers, to encourage them to bring more provision to the market so that we can meet those needs quickly.

David Torrance: On a different subject, can you update the committee on the redesign of out-of-hours care services?

Michael Kellet: As, I think, Mr Torrance will know, the IJB debated that issue at its meeting on Friday last week. I am pleased to confirm that the IJB took what was a difficult decision to approve a new clinical model of out-of-hours GP care on the basis of unequivocal clinical advice that that was the right thing to do. The new model, which we will begin to implement—our plan is to have it in place before the winter—is an out-of-hours service with three centres: one at the Victoria hospital in Kirkcaldy, one at the Queen Margaret hospital in Dunfermline and the other at the community hospital in St Andrews. The services in Dunfermline and Kirkcaldy will be open for 118 hours a week, at all points when GP services are not available. The St Andrews model will be more flexible, focusing on when there is greatest demand, such as at the weekend and in the evenings. That service will be supplemented by increased capacity in home visiting, so that, when people clinically require a GP or practitioner visit out of hours, there will be more capacity to provide that.

The other thing that the IJB approved on Friday was a new transport policy to support the out-of-hours service for those few individuals who cannot travel to a centre that is clinically the right place for them to be seen. We know that 94 per cent of people who access centres out of hours either drive themselves or are driven by a family member or friend, but, for the small number who cannot access centres in those ways, we have now approved a policy whereby they can be supplied with a taxi. That was part of our decision making as well.

Another really innovative thing that we have done, prompted by the challenges that we faced in sustaining the existing model—Mr Torrance and the rest of the committee will know that we are in a contingency arrangement at the moment—is bring a multidisciplinary team to our out-of-hours GP service. We now have specialist paramedics

working as part of the service, and a number of advanced nurse practitioners. We are also recruiting healthcare support workers. That multidisciplinary team around GPs working out of hours is bringing real innovation and allows us to be confident that the new model that the IJB approved will be sustainable in the longer term.

I am happy to take any further questions, but I hope that that is a useful update.

Miles Briggs: This question follows on from David Torrance's question. Looking at the statistics, we see that NHS Fife has had the highest percentage increase in emergency admissions of all NHS boards. Do you put that down to the fact that you have had problems with out-of-hours services and, specifically, to not renewing the out-of-hours service in Glenrothes? What work will go on there to ensure that patients are not admitted when they do not necessarily need to be?

Michael Kellet: I will start, and Paul Hawkins may come in.

We have kept a very close eye on performance in Glenrothes. The service is currently called the primary care emergency service—PCES—and we have kept a very close eye on its performance and the number of people that it has seen since the contingency arrangements were put in place, in April last year. We have not seen a significant change. The contingency arrangements apply only for the overnight hours from 12 midnight until 8 am. We have been keeping a very close eye on the number of people that the service sees, and we know that it has remained largely the same over time, so we do not think that what you suggest is a factor.

There has been concern in the Glenrothes community, and we have worked hard to explain the new arrangements and transport policy. One concern that MSP and MP colleagues have had throughout the process is: if someone does not have access to a car, how are they going to get to a centre? The transport policy is important in getting people seen in the right place at the right time. We keep a close eye on that.

Paul Hawkins may want to say a bit more about the rate of emergency attendances at A and E.

Paul Hawkins: Over the past three months, in Fife, we have seen a rise of more than 20 per cent. I have talked to other chief executives, and they have seen roughly the same thing coming through their accident and emergency units. Obviously, that is negative and we need to deal with it.

Prior to that, we were analysing whether PCES was a contributing factor. We kept a pie chart of the number of people attending, and we could not see it changing significantly. The only positive thing to take from that is that the rate of conversion to admission has not moved. Although we are seeing 20 per cent more patients, we are not admitting a higher percentage: that figure is staying exactly the same. We are analysing the figures at the moment and working together to see what is going on. Chief executives across Scotland are doing the same. I understand that, right across the UK, the figure has moved in exactly the same way, and we need to understand that in its wider context.

Miles Briggs: What plans do you have for that? I know that, in Lothian, where we have also seen increased admissions, we are looking to establish a minor injuries unit. Are you looking to provide that locally as well?

Paul Hawkins: There is a minor injuries unit at the Queen Margaret hospital in Dunfermline, and we are signposting people to use that unit more actively, to ensure that the service is robust and provides an opportunity for a faster service. We are doing that signposting. The best signposting of all, though, is to pharmacy in its wider aspect rather than to A and E.

Miles Briggs: How do you think the GP contract has impacted on the situation?

Michael Kellet: It is early days for the GP contract. We hope that it will be a positive endeavour and programme in the sense that it will support daytime GP services to be more sustainable by building the multidisciplinary team around them. That should help to support people across the whole system, including people who might go to accident and emergency units if they feel that they cannot be seen quickly at their local GP services. We certainly think that it should be a positive factor in that regard. However, as Paul says, we need to do a piece of work to understand what is happening right across the system, given the volume of attendances that he talked about.

11:30

The decision on out-of-hours services gives us an opportunity almost to reset our communications with the people of Fife about where they should go for assistance when they need it. We can clearly explain what out-of-hours GP services will look like and what community pharmacy can deliver, when it is appropriate to go to A and E and where other support can be accessed. I have talked about the network of wells. Right across the system, we are thinking about how, in the light of that decision about what the future will look like for out-of-hours services, we can effectively communicate to the public exactly where they should go for assistance, depending on the nature of their issue.

We think that that is an opportunity moving forward.

The Convener: Thank you very much. The final question will come from Emma Harper.

Emma Harper: It is kind of a supplementary question on the cultural aspects of health and social care integration. Tricia, you said that Fife has one health board and one local authority. Dumfries and Galloway is the same. However, I hear, on the ground, that there are differences in the cultures. I am aware of some research by Jos Creese, who is a principal analyst at Eduserv, that talks about the cultural aspect of deep-rooted differences in language, governance, processes, systems and performance management. What specific cultural issues are you looking to overcome in health and social care integration? For me, as someone who worked in the NHS, three years is not a long time in which to change a culture, so I am curious about what specific cultural issues you might have that are different from those that have been identified elsewhere.

Tricia Marwick: I was referring to the ways in which the council and the health board operate. At its most simple, the councillors on the IJB are elected to serve their own constituents, whereas the non-executive members on the IJB from the health board are appointed; so, immediately, you have two different cultures sitting there in front of you. We need to make sure—I see progress coming—that people realise that they all have to work together for the good of the whole of Fife. That is what I meant about the cultures being quite different.

There are also differences in how they report things to their parent bodies. For example, our governance system, which we looked at a couple of years ago, is quite different from how the council does things. It is about getting to know things. I do not see any difficulty at all with the health board staff and the council staff working together. People get that and embrace it—it is not a difficulty.

I am talking about a difference in culture at the board level, not in the work that is getting done on the ground, which is impressive and which impresses me all the time.

Paul Hawkins: It is about the IJB coming together as a single entity and understanding that it can have a wider voice. It may be exactly the same in other IJBs, but the voice of the IJB owning the issues of both the council and the health board simultaneously is the key thing we are moving towards. In the past six months, we have started to see that grow more than ever in moving the issues forward.

The Convener: Michael Kellet, Audit Scotland talks about both staff and members facing the challenge of identifying a common interest above individual interests.

Michael Kellet: I suppose so, convener. I echo what Tricia Marwick says. What I see on the ground are real examples of innovation and creativity among staff from across health and social care coming together to put individuals and their families first.

I will give you a couple of examples. We have a particularly successful programme that we call high health gain individuals, which identifies individuals who are mainly elderly and frail and who are making most use of health services—in particular, those who are regularly admitted to hospital on an emergency basis. We have identified just south of 400 such individuals and have developed an approach, with social care and health staff coming together, to wrap care around those individuals. Over the past year, we have seen something like a 40 per cent reduction in the number of emergency admissions among those individuals. For me, that is a real example of health and social care staff on the ground coming together to put individuals first.

The other example that I often talk about involves the two children's occupational therapy services that we had in Fife before integration, which worked quite separately from each other. Quite often, individual children and their families would be on the waiting lists of both services, and there was not a lot of communication between the teams. We are now in a position whereby, in effect, those teams are working as one unit. We have drastically reduced waiting times and have improved outcomes for the children and young people who are accessing those services, and we are delivering better services more quickly.

There are a range of examples of staff on the ground coming together, which is positive. As we have said, there is room for manoeuvre around how we come together at the top of our organisations, around governance, but we are making good progress there as well, as we have described.

Emma Harper: Thank you.

The Convener: I thank all our witnesses for their evidence this morning.

11:36

Meeting continued in private until 12:32.

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