OFFICIAL REPORT
AITHISG OIFIGEIL

# Health and Sport Committee

**Tuesday 3 September 2019**

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

# Tuesday 3 September 2019

CONTENTS



## HEALTH AND SPORT COMMITTEE
**18th 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:**

David Garden (NHS Highland)
George Morrison (Argyll and Bute Health and Social Care Partnership)
Edward Mountain (Highlands and Islands) (Con)
David Park (NHS Highland)
Dr Boyd Peters (NHS Highland)
Professor Boyd Robertson (NHS Highland)
Iain Stewart (NHS Highland)

**CLERK TO THE COMMITTEE**

David Cullum

**LOCATION**

The James Clerk Maxwell Room (CR4)

# Scottish Parliament

## Health and Sport Committee

*Tuesday 3 September 2019*

*[The Convener opened the meeting at 10:00]*

## Scrutiny of NHS Boards (NHS Highland)

**The Convener (Lewis Macdonald):** Good morning and welcome to the 18th meeting of the Health and Sport Committee in 2019. I ask everyone in the room to ensure that their mobile phones are switched off or to silent mode, please. It is acceptable to use mobile devices for social media purposes, but please do not take photographs or record proceedings.

I have received apologies from Alex Cole-Hamilton, who will join us soon but is not able to be here for the commencement of the meeting.

I welcome Edward Mountain, who is not a member of the committee, but is a member of the Scottish Parliament for the Highlands and Islands region.

Item 1 is evidence from NHS Highland, as part of a series of sessions that the committee has held with territorial health boards from across Scotland. I welcome Boyd Robertson, who is the board's chair; Iain Stewart, who is its chief executive; David Park, who is the chief officer; David Garden, who is the interim director of finance; Boyd Peters, who is the medical director; and George Morrison, who is the deputy chief officer of Argyll and Bute health and social care partnership.

I do not think that it will surprise anyone to hear that we want to start by considering bullying, which has been the headline issue that has affected NHS Highland in the recent past. May I have a report on current levels of bullying in the board?

**Iain Stewart (NHS Highland):** Thank you, convener.

NHS Highland absolutely accepts the findings of the Sturrock report and will not tolerate any bullying. We have started engagement events with all our workforce throughout NHS Highland, from Caithness in the north to Argyll and Bute in the south, and we have produced a draft action plan. It is a skeleton plan. It is important that it be developed with our people and our staff: that is the most essential thing.

Our plan covers communications and engagement with our staff, our organisational development, our workforce development and our human resources processes. It looks to support our staff who have been bullied and it looks at governance within the organisation. We are pulling together a plan that covers all those issues.

**David Stewart (Highlands and Islands) (Lab):** I echo the convener's welcome to NHS Highland.

I recognise that there has been a change in leadership since the bullying saga kicked off. I will not mention everyone: Iain Stewart is the new chief exec and Boyd Robertson, whom I know well from his Sabhal Mòr Ostaig days, is the interim chair. Gentlemen—welcome to your new posts.

You will know that NHS Highland is my home board. I have been dealing with the board for 20 years, in two different Parliaments, and I was probably the most shocked that I have ever been when I attended a meeting at Eden Court theatre, to which 60 people turned up. Edward Mountain was also shocked. I thought that I knew, from casework, a little about the issues that were affecting the board, but I was genuinely shocked by the number of people who raised issues to do with bullying in a range of the organisation's strata.

My first question is to ask whether there will be a scheme of psychological counselling for staff who have been bullied, some of whose careers have been ruined and who are now unable to work.

**Iain Stewart:** Yes. One of the workstreams in our action plan is about supporting our people who have been bullied. We are looking at various ways of supporting those people, including counselling, mediation and support from the occupational health department. We, too, have been hearing the bad stories. The chairman and I have welcomed colleagues who want to come and speak to us, and we have listened to what they have said about the harm that has been caused—there has been some harm. We will absolutely and without a doubt support those people as much as we can. That includes psychological help and, as I said, bringing together various colleagues to support people.

**David Stewart:** The second issue that I want to ask about is compensation. My mailbag—I am sure that this is the case for Edward Mountain, too—has been full of cases of people approaching me to say that their careers have been ruined and they have lost out financially. Is the board considering a scheme of compensation to help staff whose careers have been blighted in many ways, and who are unable to work?

Obviously, for reasons of confidentiality, I cannot cite the cases today—the individuals have requested that I do not. However, I can say that numerous people have brought their cases to me, and I am highly concerned about the effect that the situation has had on their careers. The bulk of those people are within the NHS Highland area.

**Professor Boyd Robertson (NHS Highland):** We are aware of those cases. I have personally met a number of those people, as has Iain Stewart, in his role as chief executive. We are working through the recommendations of the Sturrock report. Last week, we had a retreat—a strategy workshop, to be exact—to look more deeply at the recommendations, which was something that John Sturrock recommended we do. Compensation is one of the areas that we will be looking at, but we are not yet at the stage at which we can give a definitive answer about how we will deal with that.

**David Stewart:** It is important to consider whistleblowing and whistleblowing champions. I was concerned that the whistleblowing champion resigned after two months in the job. Again without breaching confidentiality, were there any particular reasons for that? We have previously described the culture in the board—albeit that it was under a different regime—as "toxic". Did that toxic climate affect the whistleblowing champion?

**Iain Stewart:** I do not believe so. We have very quickly taken on a new whistleblowing champion—Jean Boardman, who is one of our new non-executive directors. We are pleased that she was willing to take up that post.

**David Stewart:** Do you have any comments about the premature resignation? Two months is not a long time to be in post.

**Iain Stewart:** The non-executive director who was in the post was in post for a period before that. I have been given no information about why she resigned.

**David Stewart:** In wider terms, I will ask about the most important issue that is facing the board. I am as concerned as all of you are about NHS Highland's ability to attract able staff from the rest of Scotland and the United Kingdom. In talking about finance, we raise the expense of locums and difficulties with retention. Attraction and retention of staff are major issues. What are the board's thoughts on that? I understand from previous meetings that you have strengthened the HR component of the board. From an outside perspective, that seemed to be a fairly straightforward next step. What are you going to do to strengthen HR and the culture to ensure that people want to come to work for the board and want to continue working for the board?

**Iain Stewart:** One of the first things that we had to do was ensure that our senior leadership team was strong and in place. That is what we are currently working on. As you said, we have a new HR director, who started just a month ago. We also have a new medical director, who started in the past month.

We absolutely need to strengthen our HR processes. We are working with NHS Scotland on the "once for Scotland" approach to HR. We are looking forward to the introduction of that approach, as we believe that it is a sensible way forward. We have asked our HR director to examine the structure in the HR department in order to ensure that we have a structure that equips us for the future. I am absolutely adamant that the culture in NHS Highland should make it a place of choice for people to work in Scotland. We want to attract the best people we can to work in NHS Highland: that is what we intend to do. The chair, the senior leadership team and I are determined to do that—first, by changing the culture in the organisation.

We believe that there are green shoots in respect of culture change: we have had good reports from various places that the culture is changing. We conducted an iMatter survey and, for the first time, got a response rate of over 60 per cent. Out of 33—I think—categories, which are designated red, amber, yellow or green, we had only four yellows, and no ambers or reds. One of the yellows concerned visible leadership: the chair, the senior leadership team and I are determined to act on that. We are working across the whole of the Highlands and Argyll and Bute to speak to all of our people, so that they get to know us and we get to know them. That is really important; therefore, absolutely the first thing that we will do will involve communications, engagement and our people.

**David Stewart:** The message from all my colleagues in the committee is that bullying is not acceptable anywhere in society—in the public sector or the private sector. In simple terms, it is about abuse of power, and it is clearly easier for people at senior levels to do it to junior staff. I am sure that the message that Iain Stewart and Professor Robertson are putting out is that abuse of power is not accepted at any level of NHS Highland, that the organisation is a good place to work and that we have to get this right.

**Iain Stewart:** We want to make NHS Highland the best place to work; bullying is absolutely not tolerated.

**Professor Robertson:** We have twice apologised publicly for the behaviour that preceded the Sturrock report, but we are conscious that it takes some time for bullying to stop. Therefore, we must have ways in which to check, and to make early interventions in, situations in which there is unacceptable behaviour.

**Emma Harper (South Scotland) (SNP):** I am interested in what Iain Stewart said about the new HR director's focus on prioritising communication, engagement and people. You just said that the

iMatter survey had a 60 or 61 per cent response rate.

**Iain Stewart:** Yes—60 per cent of our staff responded. That is the first time that we have had such a high response to an iMatter survey.

**Emma Harper:** In our papers, we received information saying that the response to your iMatter surveys had been below what was considered to be acceptable for the feedback to be made part of national consideration. What did you do differently this time to engage your staff to participate in the iMatter survey?

**Iain Stewart:** To provide feedback from iMatter, we are required to get a 60 per cent response rate, which we achieved this year. We communicated a lot with staff to let them know how important it was to give feedback. Staff must realise that it is important, in order for us to make the future better, that we hear from them about what we must change. We are visiting our whole workforce throughout the Highlands so that we can understand from them, face to face, the issues that they face and how we can make NHS Highland a better place to work.

**Emma Harper:** I am interested in the change management methodology. When change happens, people sometimes feel that management imposes it on them, rather than working with them. As a former national health service employee, I understand that the NHS is a high-pressure environment in which to engage with staff. Now, health and social care integration is also happening. Is adaptation to change partly about identifying who the change agents and early adopters are, and about how to work with people who perhaps do not adapt so easily to change?

**Iain Stewart:** As an organisation, we are visiting, and holding workshops with, all our staff throughout NHS Highland. Non-executive directors and directors are part of those workshops. On Friday this week, we will visit Caithness, and we will visit Argyll and Bute down south. We have already visited Skye and we have held three events in Inverness. People come to those events to talk directly to the executives and non-executives, and we listen to them. I find it really good that people who are taking part in the events come up to us and say, "How can I be part of this? I want to work with you in developing a different culture in the organisation." People are offering us their support to do that.

**Brian Whittle (South Scotland) (Con):** Good morning, panel.

Something important was missed when we were talking about bullying. You talked to my colleague David Stewart about your interventions with people who have reported being bullied, but what interventions have you made with those who perpetrated the bullying? What sanctions or training have been put in place?

**Iain Stewart:** We need to take it case by case. Allegations of bullying and investigations into those allegations are on-going, and we will work through the HR process. However, we want to ensure that we do not go straight to an HR process. An important lesson that we learned from the John Sturrock report is that we should not necessarily go straight to the HR process, but should first look at things such as mediation, so that we can pull people together and work together to get an understanding of what has happened, why it has happened and how it has made people feel. It is not about going straight down the HR disciplinary route; it is about working out the best way to deal with individual cases. However, if bullying occurs and we have to go through the HR process, we absolutely will do that. We do it at the moment, but we must also look at other ways of dealing with bullying.

**Brian Whittle:** Is mediation not an HR process?

**Iain Stewart:** It is an HR process, but we wanted to look not only at internal mediation but at external mediation. People might feel more comfortable with external mediation.

10:15

**Sandra White (Glasgow Kelvin) (SNP):** Has the bullying had an effect on staff recruitment and retention?

**Iain Stewart:** I do not know how many posts have been affected by bullying. There are many reasons in NHS Highland for difficulties that we face with recruitment and retention, including the geography of the Highlands, housing, rurality—

**Sandra White:** I am sorry, I did not want to interrupt. I hope to come on to recruitment and retention, but I want to ask specifically about bullying. When people leave, do they say that they have been bullied or have heard about bullying? Is that why you cannot recruit or retain staff? I just want a simple yes or no.

**Iain Stewart:** We have had correspondence from, and discussions with, people who have left who have said that they did so because of bullying, but I do not know the exact number.

**Professor Robertson:** There are people in that category, and there are also perpetrators who have left the organisation.

**The Convener:** Before we move on from the Sturrock report, Alex Cole-Hamilton has a supplementary question.

**Alex Cole-Hamilton (Edinburgh Western) (LD):** I apologise for my late arrival.

Most of the questions have been covered by my colleagues, so I would like to use my time to discuss other issues later in the meeting.

**The Convener:** I am very conscious that, thus far, we have heard only from the chair and the chief executive. I am conscious also that we have an all-male panel, which is unusual in this day and age. Would the other witnesses like to add anything before we move on from the Sturrock report? The report has clearly set the context for everybody's work in NHS Highland in the recent past.

**David Park (NHS Highland):** I will, if I may, add my response to the previous question. We recognise that our staff are one of our greatest selling points and are the facilitators of recruitment. Although I have not heard about anybody resigning recently specifically because of bullying, the issue has undoubtedly affected morale and has made it more difficult to do a positive sell on an organisation of which so many people are proud. There is a strong will among the people who work in the organisation to restore its reputation, and to be proud again of the place that they work and the care that they ultimately deliver. In a local sense, staff still get positive feedback from patients—or clients, depending on whom they are caring for. However, there is no doubt that the issue has created a cloud that hangs over us, so there is determination to move forward and restore the reputation of the organisation.

**The Convener:** We move on to finance.

**Brian Whittle:** Another thing that we need to look at closely is the board's financial position. You required brokerage last year—for the second year in a row, I think—to the tune of £18 million. You currently sit at level 4 in the Scottish Government's escalation framework. A number of interventions have been required, including external consultancy. What level of brokerage does the board expect to require in the coming years?

**Iain Stewart:** We expect to require brokerage of approximately £11 million this year and £8 million next year. We hope to break even in the third year.

**Brian Whittle:** The cabinet secretary made a commitment to write off the board's debt. Is the brokerage that you just mentioned included in that commitment?

**Iain Stewart:** No. We do not know whether the £11 million for this year and the £8 million for the year after will be settled, but we fully accept that we might be required to pay it back in the coming years.

**Brian Whittle:** What are the key cost pressures that sit with the board year on year that mean that brokerage is required?

**Iain Stewart:** The three main overspending areas are medical staffing—particularly locum medical staffing—drugs and social care.

**Brian Whittle:** You suggest that you fully expect to have to pay back the excess brokerage. How will that impact on service?

**Iain Stewart:** When we manage to come into financial balance in the coming years, we hope that non-recurring funding will help us to pay back the brokerage in year 3. My colleague David Garden will give you more details.

**David Garden (NHS Highland):** We fully expect to have to repay our brokerage once we are back in financial balance. Although we have not factored that into our plans, because that will come after year 3, we expect that fortuitous non-recurring benefits will materialise every year. Rather than digging deeper by finding recurring savings to pay off brokerage—which is a temporary loan, for want of a better phrase—we will use any non-recurring benefits to pay back the brokerage over a period of time that we will need to agree with the Government.

**Brian Whittle:** What plans do you have in place to break even, in the first place, and pay back the brokerage?

**Iain Stewart:** This year, we had very welcome assistance from PWC, which came in for six months and helped us to set up our own programme management office, which helped us greatly. PWC's time with us has now ended. This is the first time that we have had such an office in recent years, and we have built up a team that will help us deliver our plans.

This year, we hope to make savings of £28 million. The schemes that are going through our system are valued at £30 million. That is un-risk-adjusted. When we risk-adjust the figures, we are left with an anticipated saving of £23 million this year, with several months of the year left. We want to get up to £28 million, so we hope to raise another £5 million of savings this year. We believe that we are on target to achieve that. Of course, we have other cost pressures such as medical staffing and locum staffing. That does not take account of our non-recurring costs; we have non-recurring savings on top of that to help us.

To summarise, we have a target of £28 million of savings this year. Un-risk adjusted, we believe that we will achieve £30 million of savings. The figure goes down to £23 million when it is risk adjusted, with a £5 million gap to be found in savings this year.

**Brian Whittle:** To clarify, are you on a three-year plan to break even?

**Iain Stewart:** Yes. We will break even in year 3. That is our aim.

**The Convener:** To be clear, is the £5 million gap of, as yet, unidentified savings in addition to the £11 million of brokerage? In effect, there is a gap of £16 million.

**Iain Stewart:** Absolutely, yes.

**David Stewart:** I will raise what I hope is a more positive aspect of financing: spending to save. Mr Stewart will be aware of my local campaign to have a PET scanner in Inverness—perhaps at the centre for health science. For those who were off school that day, I clarify that a PET scanner is a positron emission tomography scanner, which is used in diagnosing cancer. I asked some parliamentary questions on the issue and found out that 400 Highland patients went to the central belt for their PET scanning, at a cost of £400,000 a year. Clearly, there would be on-costs for capital and extra staff, but I am a great believer in the decentralisation of health whenever possible. I have discussed the issue with Mr Stewart. It would be a huge development for the Highlands. Will Mr Stewart give the committee an update on whether getting a PET scanner is a possibility? I have also raised the matter with the cabinet secretary.

**Iain Stewart:** You are quite right. We believe that, roughly, one patient a day—between 350 and 400 patients a year—could take advantage of a PET scanner in the Highlands. I believe that there are five PET scanners in Scotland—two in Glasgow, one in Edinburgh, one in Dundee and one in Aberdeen.

They are distributed centrally by NHS Scotland, which I am sure will locate them to look after the needs of the whole population. Any extra facility in the Highlands will be appreciated.

**David Stewart:** I do not want to go into too much detail at this stage, but the other obvious key point is that it would be beneficial not just for the finances but for Highlands and Islands patients as it would reduce travel costs and inconvenience in that huge geographic area.

My next point is about PET scanner supply issues with regard to radio pharmaceuticals—I am not asking for a reply; I am sure that you will look at it. Perhaps you can do a bit more work on the provision of cyclotrons and raw materials from Aberdeen, Dundee and Glasgow. I will not bore you with post-Brexit issues, but it is important to look at the thought process behind the provision. I re-emphasise the great opportunity for the centre for health science to provide a future home for a PET scanner.

**The Convener:** Thank you very much—that is noted.

**Miles Briggs (Lothian) (Con):** Good morning, panel. I will carry on with questions on finance before moving to other board evidence that was submitted. New medicine costs were mentioned. Your evidence pointed to potential cost containment but, in the detail that was provided to us, the spend on new medicines was just £34,621. How does the report's statement match that figure? It would be useful to understand that.

**Dr Boyd Peters (NHS Highland):** This is a good start for me, as I do not know the answer. A large number of new medicines come on stream in every health board. Some uptake depends on the specialists who are involved in specialist treatment, and some data that is supplied depends on what medicines are classified as new—once they have been around for so many years, they are not so new but are more mainstream. It is difficult to be precise without knowing the specifics of what was submitted.

We need systems in place to consider new things so that they are applied in line with NHS Scotland policy, and our usual forms of prescribing are not an outlier.

**Miles Briggs:** Following the meeting, perhaps you could get back to us in your own time. Perhaps the figure in the evidence was a typing error, but it seems very low.

Mental health services are a challenge across Scotland, but targets have not been met in overall NHS Highland performance. With regard to the additional resources that have been made available, what is the health board doing to take forward reforms of child and adolescent mental health services and more general mental health services?

**Dr Peters:** There has been additional investment, particularly in psychological therapies, in services for children and adolescents and for adults. It is a national challenge and most health boards are trying to achieve the Government-set targets. NHS Highland is working in that framework and is committed to improving its stats, which were reasonable and in line with many other boards but still have room for improvement.

**Miles Briggs:** I thank you for kindly setting up my visit to Raigmore with Edward Mountain—in April, I think—when I was impressed by all the NHS staff whom I met. You have outlined the challenges with regard to a rural board attracting people, which the committee has had many conversations about. What innovations will be needed to attract NHS workers and which are being taken forward to retain staff and attract new people to Highland? You said that lots of new graduates come to do initial training but then leave. What more does national Government have to do about that?

**Iain Stewart:** We are doing a lot.

10:30

I will give you an example from Raasay near Skye, which is a very rural part of the Highlands that requires a nurse. We work with the community to pull together advertising campaigns on such things as the recruitment of staff to the distillery, in order to attract to the island not only NHS staff but staff for other parts of the workforce. It is important that we do that with Highland Council, and that we come together as a group to recruit families, as well as individuals. An outstanding number of people have applied for the post. How many applications did we have?

**David Park:** We had 27. In broader terms, there is no single resolution to the recruitment issues, which have to be looked at from the point of view of the skills sets for the posts that are being recruited to, and the nature of each location. We face different challenges in Raasay and the rest of Skye and Lochalsh from those that we face in Caithness. It is good to involve communities and interested parties such as local councils or employers—as we did in Skye—in looking at how we can attract families and make it easier for them to move to a community. Typically, it is not just about attracting one spouse or partner to a job; if we are trying to bring people into a location, we need to think of the family set-up and the spouse's work. When we post our roles we tend to do so on an individual basis, whereas taking the approach that I have outlined allows us to attract a family. We recognise that each locality has different selling points that can attract people. The driver might be the spouse's job, which is not necessarily within the NHS, or it might be that the NHS role is the draw and the partner still needs a job, as a teacher or something else. We have combined those ideas and created that opportunity in one small area so far, but there could be further opportunities to do that.

**Dr Peters:** That is a broad question with a broad answer, which we talked about when Miles Briggs visited.

It is clear that it is not the scenery but other things that are attractive, such as the job conditions, the availability of research and education. Miles Briggs will remember that one of our conversations was about deaneries and universities placing students or postgraduate doctors and other staff in areas such as the Highlands, so that people can experience delivering care in that environment. It is up to us to provide them with a good experience when they come.

However, the allocation of people to places such as Inverness should be looked at. There also needs to be a national drive on the development and education of people in nursing and the medical workforce. We have serious workforce challenges nationally that are a bit of a time bomb that is beginning to explode. We will need an increased number of those staff groups over the next decade. In fact, we could do with them immediately in some cases. The issue is very broad.

We are looking regionally for solutions for some of the specialist services. We are also thinking about flexible job planning and arrangements, as people now work and families now run themselves differently. We need to flex with parents' involvement with children in relation to the hours that they work. That requires a lot of innovation at regional and national, as well as local level—and definitely within education. Our final plea is that we—and you—do what we can to promote support for those who are in schools, in the Highlands for instance, to be helped into the education that I mentioned, and we hope that some of them will come back, in due course, to become the next doctors, nurses and physiotherapists that we need.

**Iain Stewart:** Another issue in the Highlands is housing. In Skye and Raasay, housing is absolutely an issue when it comes to attracting staff. However, in Raasay, for instance, we have worked with Lochalsh and Skye Housing Association to provide housing for staff. Again, it is about working with partners to ensure that we can attract the right people.

One of the things that we have done in the Highlands is look at midwives, as there is a shortage of midwives there. For a second year, we have brought in an accelerated midwife course, so that currently qualified nurses can train to become midwives in 20 months. The course is attracting nurses from all over the Highlands and Islands to come to the area and become midwives. We have a need for midwives and the accelerated course will assist us with that.

As Dr Peters said, it is about thinking innovatively about how we can do things, but it is also about looking at our range of professional people—for example, whether we can use advanced nurse practitioners rather than other professionals. It is about looking at the development of our existing staff in order that they can step up and do other roles, which we are very keen on and which we have to do.

**The Convener:** Does George Morrison have anything to add in relation to Argyll and Bute?

**George Morrison (Argyll and Bute Health and Social Care Partnership):** I do not have a great deal to add, to be honest. All the comments that my colleagues have made are relevant to Argyll and Bute. We have the same issues: we have an ageing workforce and we have difficulties with staff recruitment and retention. Housing in certain areas

is also an issue. Those are very common themes and we follow the board's lead in trying to address such matters.

**Brian Whittle:** I am looking at the performance figures, and what stands out for me is the cancer treatment performance, especially around the treatment time guarantee. The issue is not unique to the Highlands and Islands and certainly not to an area of such rurality. What thought has been given to how the board will close the gap in the treatment time guarantee? I know that other boards have looked at community-based treatment of those cancers for which that is appropriate. Has that been considered, and are there any plans around such satellite or community-based treatment?

**Iain Stewart:** With regard to our cancer waiting time of 31 days, the target is 95 per cent. In June, we managed 95.6 per cent, which we are very happy with. That is against a Scottish average of 94.9 per cent. With regard to the 62-day target, the figures are not so good—in June, we achieved 83.6 per cent against a 95 per cent target, and against a Scottish average of 81.4 per cent.

Many of our issues are around urology. That is the case not only in NHS Highland but throughout the whole of Scotland and the UK, because there is a great demand on urology, in relation to prostates and so on. We have had locums working on that and things are improving, but Dave Park may be able to give more details in relation to the cancer issue.

**David Park:** I am happy to. As Iain Stewart mentioned, urology is one of the relevant areas. Our fragility is due to the delivery model being through single-handed practice. Therefore, in order to flex capacity or deal with an increased number, the regional agenda is extremely important to us, in particular our partnership with NHS Grampian.

Recently, a consultant moved from NHS Highland to NHS Grampian, but is going to continue to treat NHS Highland patients in Grampian. Urology is an area in which such ties are extremely important, as there are so few specialists in that area.

The numbers are actually quite small in absolute terms. Of course, we want to provide the best care for every patient, but the numbers are relatively low, therefore the difference between success and failure in that regard is relatively slight. It is important that we continue to build on the relationships and I know that Dr Peters has been involved in the north Highland cancer programme.

**Dr Peters:** There is no easy answer and there is a lot of detail in answering the question. We are looking at all the various possibilities—there are a number of different elements of work and effort in addressing the TTG and the regional approach is one of many bits of that jigsaw.

We are committed to the TTG. It is a challenge for all boards at this time, and there are new variables in the equation that are making it a little bit more difficult than was the case previously. I think that you will be aware of, for example, the pension and tax issues for senior doctors, which limit the amount of extra time that they will commit to such work, which is often additional work that we do.

There are challenges in meeting the TTG, some of which are national as well as local.

**The Convener:** Clearly, the targets are to be met, but I think that an earlier answer on CAMHS suggested that it is no great surprise that we could not meet them. Have you ever met CAMHS targets? Do you have an idea of when you might meet CAMHS targets?

**Dr Peters:** I do not think that we have a projection of when we will do that. Again, CAMHS is a national challenge. We are noticing nationally as well as locally that the number of CAMHS referrals is increasing year on year.

I used to be a general practitioner. The number of community referrals that was made 10 or 15 years ago was much lower. In the past decade, the referral rates for CAMHS and other psychological therapies have rocketed. In a sense, that means that we are playing catch-up—we are not just trying to reach a static target, but are chasing a target that is moving away from us. That is an additional challenge. It is difficult to say exactly when we will meet the target because it is moving and the number of referrals is increasing, but every effort is being made to do that.

**The Convener:** You are really saying that the situation is bad and it is getting worse.

**Dr Peters:** I think that we have closed some of the gap, so I would not phrase it that way. The situation is challenging and efforts are being made, but we must be conscious that the challenge is changing.

**Iain Stewart:** On CAMHS, we are getting many more referrals for attention deficit hyperactivity disorder and behavioural issues.

On the CAMHS target of 90 per cent of people being seen within 18 weeks, we are currently at 81.4 per cent, against a Scottish average of 73.6 per cent.

**Emma Harper:** I have a couple of questions on the issues to do with targets; Boyd Peters might be able to help in that regard. I have asked questions before about Staphylococcus aureus bacteraemia and Clostridium difficile infections. You are almost meeting your targets—it is not as

though you are way off. The low patient numbers in the NHS Highland area compared with urban areas where there could be 1,000 such patients makes meeting targets really challenging.

Your SAB and C diff infection rates are barely off the targets. What are the challenges in meeting your SAB targets? I know that that is not just to do with central lines and cannulas; it is to do with other issues to do with abscesses. There are challenges in meeting C diff and SAB targets.

**Dr Peters:** If she were here, the nurse director would be able to speak about that at length. Great efforts are made to address that important work. I think that our performance is usually very good but, as you say, because we treat a relatively small number of patients, it just takes a few cases to shift the percentages. The issue remains a high priority, and every effort is made to meet the target. Clinical staff in the wards are working hard to keep the infection rate as low as possible.

**David Stewart:** So that it does not get lost, I return to Boyd Peters's point about the UK pension provisions and the effect that that has had on the retention and recruitment of doctors and consultants in particular. The panel will be aware that the UK Secretary of State for Health and Social Care made a statement in which he said that the Government would try to protect the pension provision for doctors and consultants. Obviously, that is a reserved issue—it is primarily a Treasury issue to do with the lifetime allowance—but I am trying to pursue the matter. It does not appear that anything is happening in Scotland. Can the panel cast any light on the issue?

10:45

**Iain Stewart:** The Scottish Government is making representations to Westminster on that matter, which is a major issue with regard to our performance and how quickly we treat patients. We estimate that our workforce capacity for consultants has reduced by approximately 15 per cent as a consequence of the issue, which is having a big effect on the care that we provide to patients, especially in areas such as orthopaedics. It is absolutely an issue, and I often get letters about it from my consultants and other worried colleagues. However, I know that colleagues in Edinburgh are making representations to the UK Government.

**Dr Peters:** I thank David Stewart for raising the point. I appreciate that it was raised as a question, but I think that we are all of like mind on the issue. Personally, and on behalf of all the medical workforce that I represent, I am glad that you have raised the issue. We have lots of great and specialised doctors who want to provide some of the services that Brian Whittle mentioned in relation to the TTG, but those doctors are a bit hamstrung at the moment because it will cost them. They will be financially penalised if they work more, just at a time when they want to and we would like them to. That is a huge UK issue that is affecting Scotland. It is a reserved matter, but it is nevertheless extremely important to us and to the care of our patients, so I am glad that a light has been shone on it today.

**Iain Stewart:** The chair and I have met with Mr Hendry MP to discuss the issue and we asked him to raise it in the House of Commons.

**The Convener:** Edward Mountain has the next question.

**Edward Mountain (Highlands and Islands) (Con):** My question is particularly about the board, so if there is a more appropriate time for it, I am happy to wait. It is not on the current subject.

**The Convener:** Okay. We are still on performance, so I will take questions from Miles Briggs and then Alex Cole-Hamilton.

**Miles Briggs:** A number of my points have been touched on. I want to return to some of the key targets on mental health. Statistics that have been released today show, yet again, declines across Scotland in relation to CAMHS. We heard earlier about NHS staff being able to access mental health support. Given that, on psychological therapy waiting times, your board is at 76.4 per cent against the 18-week target of 90 per cent, where are you looking to get extra capacity to improve the situation?

**Dr Peters:** With adult psychology, when our current lead psychologist came on board less than two years ago, she started a review of the entire service, because we realised, before Government prompting, that we wanted to address the issue. Now that the review is done, she is implementing a raft of changes and has brought in some additional staffing. Some of the existing client or patient base has been reviewed. In some cases, the need has changed. Another issue is that, under the old system, a referral might have been well intentioned but, when a psychologist assessed the individual, they found that psychological services were not required and that something else was needed. People sometimes waited for a while in the system to be assessed only to find out that, actually, they needed something slightly different. We have changed the approach to try to take out that delay and to ensure that people are not on lists unnecessarily.

My colleague texted me this morning to advise me that the figure that you referred to is now at 80 per cent so, by the looks of it, we are steadily improving. As ever, it is a journey. As I said, with adult psychology, the referral rates are also

increasing. Society is more aware of the issue—as a society, we are slowly destigmatising mental health, so referrals are increasing. We must remember that it is a moving target.

**Miles Briggs:** I respect that point.

In the data that we have, I cannot see a figure for rejected referrals for CAMHS. I do not know whether you have that figure to hand. What work is going on around that? The committee has heard evidence that, in many cases, when a referral is rejected, the person ends up returning in crisis. What work could be done on that, perhaps with the third sector, where there is capacity in Highland?

**Dr Peters:** There is always a team approach, and that is followed when other available services and therapies can be used.

Maybe "rejected" is not a great term, but sometimes referrals are not appropriate and may not be so easily dealt with at the time with the service that exists, or not enough information might be given in the original referral to allow the person who assesses it to understand that there is something that the service will be able to help with. Like other boards, we need to work at that and ensure that we do not turn away anyone who should be seen or referred on to a different type of service. It is clear that that is a very important thing to get right.

**Miles Briggs:** On another performance area, statistics on drug-related deaths were published at the beginning of the recess. The figures for Highland are not in the briefing, but what work are you looking at? Given that national emergency and particularly the rural and island situation in the Highlands, what work have you started ahead of the Government task force? Have you had any discussions already on that? A key thing in those discussions is ensuring that we take rurality into account as one of the most challenging aspects.

**Dr Peters:** Yes. Before I became the medical director, I was associate medical director for mental health, and I sat in on our regular meetings in which we reviewed every drug-related death to see what lessons could be learned. That approach is well established and has been very useful. I single out Suzy Calder for her leadership on that.

You quite rightly alluded to societal change and our slowly seeing an increase in the numbers. In the Highlands, the rurality issue means that there are only a few hotspots. Most areas are clear of drug-related deaths, but there are a few hotspots, which I will not name here. We are aware of them, and some extra work will occur in them. Mental health teams, social work teams and primary care teams will be aware of and alerted to cases that are known about. A proportion of those unfortunate deaths are always unsighted by services prior to the sad event occurring, but the issue is high on our agenda.

**Alex Cole-Hamilton:** Good morning to the panel. I apologise for my late arrival.

I want to ask about particular aspects of provision in NHS Highland, particularly in remote and rural communities. Since the downgrading of maternity services in the far north, what risk assessment has been carried out for mothers who have to travel 200 miles to Inverness to give birth?

**Iain Stewart:** An adverse event review has recently been completed, so this has been looked at independently. It was found that the decision to transfer a patient was right and that it would not have been the right decision to transfer that patient by air or to keep them in the hospital in Caithness.

We look at the issue constantly, and we constantly find evidence that the current method of operating is the right one and is best for the mother and the baby. They are on a red—that is, a high-risk—pathway to be transferred to Raigmore hospital. One of the main reasons for that is that we have a special care baby unit in Raigmore hospital, which we do not have in Caithness, and we must always be concerned about the safety and wellbeing of the mother and the baby. The decisions to transfer are made for their safety.

**Dr Peters:** That question is probably for me.

I think that there had been a number of adverse events when the original decision was taken a number of years ago. We do not like to see those things happening, particularly when fatalities are involved. No fatalities have occurred since the change, and that is a positive. There is still a local midwife-run unit, which is similar to what we have in other parts of the Highlands.

The societal expectation these days is for 100 per cent. In the case of a high-risk birth, where the mother and baby are in crisis, there is a medical and technical need to have available not just obstetricians to care for the mother and deliver the baby but, much more important, neonatal care—intensive care for a newly born, sometimes premature and probably unwell baby. That is a very specialised service that requires a specialised facility. To minimise risk—

**Alex Cole-Hamilton:** I am sorry to interrupt you, Dr Peters, but I am not sure that you understood my question. I am not asking about the reasoning behind the downgrade—I understand that. I am asking about resilience and risk planning for pregnant mothers who are in labour and who have to be transferred 200 miles to Raigmore. What happens when the A9 is blocked, for example? What is your contingency planning for that?

**Dr Peters:** Right—I have got you. The number 1 point is that the clinicians who are directly involved will, with the mother, decide where birthing would be appropriate. If a situation arises in Caithness—the transfer is 120 miles—in which someone is thought to be low risk or perhaps presenting prematurely and therefore not yet at the time when they would have a birth, we make use, on those unusual occasions, of the Scottish Ambulance Service. If the road is blocked, there is air transport, but we usually prefer road transport. The use of air transport has occurred in a very small number of incidents.

**Alex Cole-Hamilton:** How many mothers have had to be flown to Raigmore?

**Dr Peters:** Flying is unusual when someone is actually in labour—it is not usually done.

**Alex Cole-Hamilton:** You have now answered my question about what happens when the A9 is blocked—you said that you might transfer the patient by air but that that is unusual and not ideal. I am not getting confidence that there is a proper resilience plan for what happens if that situation occurs.

**Dr Peters:** That is why we plan ahead and make sure that any person whose delivery is likely to be high risk comes to Inverness before the time of their labour. The problem that we have, no matter where a person is, is that some people go into very premature labour unexpectedly; that is a challenge that we have to deal with on a case-by-case basis.

**Alex Cole-Hamilton:** Moving on to another area of provision, I have heard of a number of examples of cases in the north-west of Sutherland in which home care has not been delivered as expected, with people waiting days on end for carers to attend. Can you explain why that is?

**The Convener:** Who wants to respond to that question on home care?

**David Park:** I am happy to do that. The answer somewhat goes back to our recruitment issue, which we described earlier. We have increased the number of hours of home care provision across NHS Highland to around 15,000. Home care is therefore provided at a significantly higher level than was the case before, which represents the demand that is placed upon us. There are certain areas where it is more difficult to recruit for home care. We use a combination of in-house provision—our own employees—and the independent sector. We recently created incentives for the independent sector to expand its capacity, in particular in areas where provision is more difficult and where there is a waiting time, which we are hopeful will help us to expand the capacity that is needed in those places.

**Alex Cole-Hamilton:** So it is about capacity—you have just not had the workers you need to fill shifts in more rural areas.

**David Park:** Yes. Although we are always considering our processes—they can always be improved and the time that they take shortened—it is predominantly a capacity issue.

**Alex Cole-Hamilton:** Turning to another area of provision—I promise that this will be the last one—I understand that corrective eye surgery is currently on hold because NHS Highland cannot afford the cost of patients being treated in Aberdeen by NHS Grampian. Why can NHS Highland not perform such surgery?

**Dr Peters:** Which type of surgery?

**Alex Cole-Hamilton:** Corrective eye surgery.

**Iain Stewart:** We do not currently know of any issue with regard to that type of surgery or to the cost of it. However, we will look into that.

**Alex Cole-Hamilton:** Please do. If you could also write to the committee, that would be helpful.

**The Convener:** If you could write to us on that issue, on the issue of air transfers of women in labour—Boyd Peters was not sure of the numbers—and on the cost of medicines, that would be helpful.

11:00

**Sandra White:** I would like us to get clarification on the subject of air transfers of women in labour. My understanding is that women who are in labour are not transported by air.

**The Convener:** That is my understanding as well. [*Interruption*.] Order, please, colleagues.

Dr Peters indicated that, in the event of there being a difficulty with road transport, such situations would be addressed by an air transfer, but the understanding around the table is that women in labour are never transported by air. Therefore, we need a clearer answer on what happens when the road ambulance is not available.

**Dr Peters:** To be clear, I agree that an air transfer should not occur when someone is in labour. It depends on the circumstances of the case, but I accept that, if the road is blocked, that will present some difficulties for the decision makers—the clinician and the ambulance crew.

**The Convener:** I am sure that the issue has been thought about, but it would be useful to have a note on what the thinking is about the approach in those unlikely but not impossible circumstances.

**Emma Harper:** I have a quick point of clarification. The same issue arises in relation to

Stranraer and Dumfries. Patients are very well risk assessed right through pregnancy. If there is an issue, as soon as labour starts, they may be transferred to the appropriate place to deliver. These days, risk assessments are carried out throughout pregnancy and there are contingencies in place to avoid a need for intensive care when there are no intensive care beds, as is the case in Caithness.

**The Convener:** Do you also have a question on performance?

**Emma Harper:** Yes. My question is about performance management. A lack of adequate systems has hindered the delivery of some of the organisational goals. According to NHS Highland's submission, the new performance management system will be "output driven" and linked to the annual operational plan. Could you provide a bit more detail on what the new performance management system will involve and what was lacking previously that hindered the delivery of organisational goals?

**Iain Stewart:** Part of our new structure is looking at the performance management framework. The senior leadership team realises that we do not have a full understanding all the time of where we are as regards performance, and we want to drive that forward as soon as possible. That is all part of our governance review to ensure that our governance is appropriate.

We are working with the performance director to develop a new framework that will give us up-to-date information on where we are with all our performance measures and specialties on a weekly basis. That is a priority for the senior leadership team at the moment.

**The Convener:** I want to move on to the provision of health and social care through partnerships. Two different models operate in the NHS Highland area. Could we hear a bit about the merits of the respective systems and the perceived differences between them? Perhaps David Park and George Morrison would like to comment on that.

**David Park:** Highland has a unique integration scheme, which was established in 2012, prior to the legislation on integration joint boards. Many people, including me, do not know what it was like to have an unintegrated system, but meeting colleagues and other chief officers in the other integrated authorities enables us to compare what goes on.

Integration has been established in north Highland for some time. Our best integration takes place where provision is delivered by teams that are locally based. We work with multifunction, integrated teams within a locality; the teams contain multiple disciplines, which are both health and social care related. Our third-party and independent providers might also be part of the team. We work together to provide care for the community.

The models differ somewhat in the more formal areas. Our current partnership agreement with Highland Council is due to expire in March and we are in discussion with the council about updating the agreement. The discussions have been positive. The council is keen to continue the current model and recognises the success that it has had.

Highland Council staff have been transferred to the health board over time—that is one of the significant differences between the IJB model and the lead agency model. Likewise, health board staff were transferred to Highland Council. That was a significant change. Although there are small pockets where resolution is still to be made, there has been resolution in the vast majority of cases. It makes for a much more integrated approach. People work in the same buildings and teams to the great advantage of the people for whom we care.

**George Morrison:** The IJB in Argyll and Bute was established in 2016 and has been operating well—we are now in year 4. There has been significant progress.

There has always been a large degree of collaboration and co-operation between health and social care services in Argyll and Bute—that is common in remote and rural areas. The IJB has enabled us to build on that. A number of teams have been co-located or put under a single management tier, so there has been a lot of improvement in the organisational structure for managing the delivery of health and social care services. I am not aware of significant concerns or issues to flag up.

**The Convener:** From the board's perspective, which of the two—significantly different—models is most effective in dealing with delayed discharge?

**Iain Stewart:** The board has not compared the delayed discharges of the health and social care model in the north with those of the IJB model in the south. We have not done that piece of work yet.

**The Convener:** I take it that you have followed the development of delayed discharge in both areas.

**Iain Stewart:** Yes. We are looking at the six standard practices that we use for delayed discharge—we are working on that.

What is more important than considering delayed discharge is looking at admissions that are not required. If we can avoid unnecessary admissions, we can prevent problems of delayed

discharge at the other end of the system. We are looking at not only the back end but the front end of the hospital, to ensure that when people come to the front end who require social or community care, we put care in place at the beginning—that is, while they are in the emergency department, rather than waiting until the person has gone through the hospital system and discharge is being delayed at the end of the process. We are looking at the whole flow from pre-acute at one end to discharge at the other end.

**The Convener:** I accept that avoiding unnecessary admissions will, by definition, avoid delayed discharge at the other end of the process.

We heard that the agreement with Highland Council is due for renewal next year. Given that, I would expect you to be measuring whether the lead agency model has been more effective than the IJB model that is used elsewhere, and I would have thought that considering delayed discharge would be an obvious way to measure effectiveness.

**Iain Stewart:** We are working on agreements for north Highland and Argyll and Bute. It is not just the north Highland scheme that is up for review next year; the Argyll and Bute agreement is also up for review, next July. We are looking at performance in both areas, and in north Highland we have just made a joint appointment of an officer, across the council and the NHS, to advance that work over the coming months.

**The Convener:** Can I ask David Park and George Morrison to comment on changes in delayed discharge in their respective areas?

**David Park:** As I mentioned earlier, capacity issues in social care—care at home and in care homes—are a significant challenge to us across the region, and we are working hard to reduce delayed discharge in those two areas. In care homes in particular, significantly more capacity should be coming in over the next 18 months in Highland. A number of hospital delays are related to care home capacity.

We also have the aspect of the geography of the region. It is not enough to have capacity in one particular location, because people want to be located close to their families and localities. There is a strong preference element, about which care home to use, which has a significant impact. That is why care homes is one of the areas that we are looking at.

One of the opportunities provided by the current scheme of integration in north Highland is that typically a transaction point appears between the acute sector—if I can describe it that way—and social care, which is at the point of discharge. We have identified that there is a pre-discharge area that we can focus on, which is what we would call post-acute patients. Those patients may have passed the most acute part of their medical care but they are not ready for discharge. We are trying to intervene at that point so that it becomes more of a pull from the hospital rather than a push from the hospital. Our dual responsibility allows us to work across those boundaries that might be more difficult.

**The Convener:** How does your level of delayed discharge compare with the levels in other parts of Scotland?

**David Park:** I will be honest and say that the level is not as good as those in other parts of Scotland, but I suggest that that is predominantly because of the capacity issues that we face, which I mentioned earlier. That is one of the challenges that we are trying to address.

**George Morrison:** In Argyll and Bute, there are a couple of hotspots—Oban and Lochgilphead—where we have delayed discharge issues. There are also some issues around getting patients discharged from hospitals in Greater Glasgow and Clyde NHS. I am not aware of significant concerns in that area. My understanding is that the problems that do exist are the result of specific issues relating to patients or difficulties in care home provision. Those have been issues for some time and we are working to address them.

**The Convener:** If I can ask you the same question that I asked your colleague, how does Argyll and Bute's delayed discharge performance compare with that in other parts of Scotland?

**George Morrison:** I acknowledge that I am not an expert on the matter, but my understanding is that we are in the middle, somewhere. I do not think that we are an outlier.

**The Convener:** Can I ask again that both north Highland and Argyll and Bute provide us with the figures for this year and for previous years, so that we can understand the trend?

**Sandra White:** Good morning, gentlemen. I say "gentlemen"—unfortunately there are no women from the board. I will ask about recruitment and retention. Perhaps, next time, there will have been some recruitment of women to the board. That is not a slur against our witnesses, obviously—you are very welcome here today.

I thank you for being so honest with me when I asked about the bullying situation in regard to recruitment and retention. You will be aware of Audit Scotland's report, which describes the cost of recruitment and retention as one of the key issues. We have got £12.8 million on medical agency staff, locum staff, dentistry and so on. In addition to the issues that have already been mentioned, what is the board's main difficulties in

recruiting? I ask about medical and dental staff in particular, because they seem to be the worst.

**Dr Peters:** That is a good question. We are working on that at the moment as a priority area. As you say, we have quite a high locum spend. Some of that is a recruitment issue, where we want to recruit into substantive posts, so we will have a recruitment drive to try to address that.

There are some posts that it is difficult to recruit to. Some of that is a side effect of the trend in medicine towards ultraspecialism. Our health board is an example of where what is sometimes needed is the opposite of that—which is to say, generalism. We need our specialists to be able to do a variety of things rather than dealing with one small element in a regional or national patient base. We need to set up services in ways that ensure that the services that we need are delivered and also that we are able to create jobs that attract people. That is why we are considering ideas around flexible work packages, building in research or education options and so on—things that might make the jobs attractive to folk. The issue is a live one for us, and we are working hard on it.

11:15

**Professor Robertson:** The situation with recruitment is patchy. We heard about Raasay and the success there. The Ullapool medical practice, which I visited, has no difficulty with recruitment, whereas the situation is more challenging further down the road in Gairloch. There is a mixed picture.

For the past two years, the three practices on Mull have been served by a series of locums. Happily, we are now moving into a more stable situation, because the Lorn and islands hospital practice in Oban will be taking over the running of the three Mull practices. On a visit to Mull last week, I heard from community representatives who very much welcomed that.

**Sandra White:** Audit Scotland's report mentioned not only recruitment but the cost of locums and so on. How much does the board spend on recruiting staff? How does that compare to the spending by other boards? Is it more expensive to recruit someone for your area than it is for other areas?

**Dr Peters:** The expense is not great, in that there is a team of staff who are involved in recruitment. There is the cost of the advert, which will surprise some people—putting an advert in a medical magazine costs thousands of pounds. That becomes a bit more of a cost if you have to advertise more than once. However, in the grand scheme of things, the cost of the recruitment process is relatively low. The big cost comes from the payment of locums to do work to provide services that you might otherwise want to be done by a substantive colleague. That is a trend that we would like to reverse. It is a significant challenge and, the further out from the central belt you go, the harder it can get. That is the reason why I made a plea with regard to how we can grow our own people, as it were, so that we can have people who want to be in the Highlands for a variety of reasons, professional and otherwise.

**Professor Robertson:** Highlands and Islands Enterprise is leading a piece of work on recruitment across all the agencies in the Highlands and Islands. That is being run through the community planning board.

**Sandra White:** I was going to ask what could be done to help recruitment, and you have answered that by saying that it would be good to have home-grown people. What is happening in that regard? Could you give us any figures about how successful that approach has been in terms of how many people have applied? It would be better if you could recruit people rather than spending all that money on locums.

**Professor Robertson:** I am happy to provide that information to the committee in writing.

**Brian Whittle:** We are talking about recruitment and retention, but I often think that we get that the wrong way round and that we should be talking about retention first. We have discussed at length your issues around recruitment and how you are addressing them. However, it is difficult to increase your capacity if you are pouring water into a bucket that has a hole in the bottom. How are you dealing with the retention of staff? How are you looking after the staff that you already have?

**Iain Stewart:** That goes back to the conversation about the culture. We want to ensure that the culture in the organisation ensures that our staff are respected, engaged with and valued. As I always say, it does not matter whether someone is a professor or a porter; every person in the organisation is really important. Without each individual and specialist, the organisation could not operate. We need to get the message out that everybody is important and respected; there will be no bullying; and, as an organisation, we want to be the top employer of choice in the Highlands and in Scotland.

From the top of the organisation, we are pushing to ensure that that message gets out. We live by those values and we need to ensure that everybody knows that and sees us working in that way. The organisation's culture is important to people and we want to retain our people in NHS Highland. We want people to want to stay on an extra few years rather than retiring, and we want

them to think twice about moving somewhere else, because the Highlands is a great place to work. That is what we want the culture of NHS Highland to be.

**David Torrance (Kirkcaldy) (SNP):** Has the board seen a decline in the number of migrant workers? If so, what has the extent of that been, and what impact has it had on NHS Highland?

**Iain Stewart:** At the moment, we are not seeing that. The main issue with regard to migrant workers and a departure from the European Union is not necessarily about NHS Highland but about the wider workforce. I am talking about care-at-home workers and care-home workers. You might think that that part of the workforce is external to NHS Highland, but if care homes are unable to take residents and care cannot be provided at home, what happens to those patients? They stay in hospital, which becomes a huge problem for us. Therefore, the issue is not necessarily a decline in the number of migrant workers who work for NHS Highland, but a decline in the number of migrant workers who work for care homes or in care-at-home jobs. That will have a huge knock-on effect on NHS Highland.

**David Torrance:** It is looking increasingly likely that there will be a no-deal Brexit. What impact will that have on the recruitment of staff, especially in areas with shortages, and on the day-to-day running of NHS Highland? What have you put in place in case that happens?

**Iain Stewart:** We are working with colleagues in NHS Scotland on EU exit procedures. That particular issue is not one of the main priorities. We are also looking at medicines management, medical devices and supplies of all the different requirements for running an NHS service, so recruitment is only one of half a dozen priorities. As I said, our non-NHS employee carers are a priority and we must fill in the right forms to ensure that they have the status to remain in the country.

**Dr Peters:** On David Torrance's question about staff retention and whether we will lose staff in a no-deal Brexit situation, the current indications are that we will not. Like all parts of the NHS these days, we have a great reliance on the EU and non-EU graduates who come to work with us. I think that many were reassured by the Scottish Parliament's statement of support for people from the EU in a post-Brexit state. We were grateful for that assurance. We have not seen any signs of an exodus but we must remain vigilant.

As Iain Stewart alluded to, there are active meetings about how we deal with Brexit; recruitment will be one of the strands that are discussed at those meetings. As David Torrance pointed out, it is beginning to look a little bit more real today.

**Emma Harper:** Just to follow up on Sandra White's questions on recruitment and retention, I agree with Brian Whittle that we need to retain as well as recruit, but we also need to train staff. I want to highlight the Scottish graduate entry medicine—ScotGEM—programme, which is the Scottish Government's programme for graduate entry to medical school. The Highlands and Islands region participates in the programme, as does Dumfries and Galloway in my region, South Scotland.

I would like to hear a bit more about ScotGEM from the panel's perspective and about projections of the benefits of bringing perhaps not just home-grown folk but other people to the Highlands and Islands region. It looks to be quite a promising programme.

**Iain Stewart:** My view is that, if a person is born, brought up, goes to school and is educated in the Highlands, the chances are that they will stay there. That is important for ScotGEM.

We find that, if our young adults leave the Highlands and go to university in the central belt, they stay there. They do not usually return. The more training such as ScotGEM that we can do in the Highlands, the better, as that will have a positive effect on attracting doctors. It is great.

In the future, on top of that, I would like to see a medical degree in the University of the Highlands and Islands. We can aspire to that in years to come and it would be fantastic for the training of doctors locally.

**David Stewart:** I want to touch on the new general practitioner contract. As you know, there has been some debate about the new funding formula, not least in our Public Petitions Committee; some people on that committee have argued that it underestimates the cost of care in remote and rural areas. Do you agree?

**Iain Stewart:** I will hand over to Boyd Peters to answer that.

**Dr Peters:** That is a thorny question: everybody has a slightly different opinion on it. NHS Highland is working with GP colleagues and GP leaders to try to implement the contract as it stands. It is a two-phase contract and phase 2 is approaching.

A special remote and rural working group that was chaired by Professor Sir Lewis Ritchie has been working. Work is being done on how the contract can be best placed in remote and rural settings, and on where the challenges are different. That is a very active piece of work at the moment, but it is difficult to say how it will play out.

You asked about finances: people in the NHS will always want more money to do more. Undoubtedly, the amount of money that is to be had from Government is finite, so it is about

optimising what is available and making sure that the formula is right. Although it is called the GP contract, it is, of course, a primary care contract in the sense that much of its effect will be on the non-doctor elements of primary care provision, and on support of stuff around the GP function that is being invested in. That is all very new, and the challenge of delivering it in Gairloch, for example, is very different to the challenge of delivering it in Govan, where there is a greater population concentration.

**David Stewart:** The witnesses will know that the committee is conducting a major inquiry into primary care, so we might have you back at a future date to interrogate you in more depth on that particular subject.

In the Information Services Division's statistics for NHS Highland, GP performers, which is the jargon for GP partners, show a head count of 251, compared to 304 10 years ago. Why has there been such a change in that number?

**Dr Peters:** There has been a rise in the number of salaried doctors working in general practice. Indeed, I saw out the final bits of my GP career as a salaried GP, so I would be one of those who disappeared, but I was still actively seeing patients. As ever, those statistics represent only a certain view. The people who run the business are the partners and they take responsibility. Nowadays, and certainly in the past decade prior to the new contract, business modelling has leaned heavily towards salaried doctors. Indeed, many of the doctors who wanted to work in general practice preferred being salaried to running the whole business and taking responsibility for the financial risks involved.

**David Stewart:** As you pointed out, Dr Peters, there has been a debate around that issue. I went to a reception—colleagues will have been to similar receptions—at the Royal College of General Practitioners just before the parliamentary recess, and its members had strong representations to make on that. Since the committee issued the call for evidence on primary care, I have been contacted by GPs and visited them at their request in Elgin and Shetland. I have to say that I heard pretty similar stories about GPs being concerned about aspects of the contract, although not about the contracts universally. The use of other health professionals is broadly welcomed, and there are issues around the health boards' assumptions that they will take over the ownership of premises in the longer term, but that might be more for our inquiry than for today. I just wanted to flag up that there are some issues.

Dr Peters—you mentioned that there is an issue about numbers. Is your point that the reduction in numbers is purely because there are more salaried GPs, but the actual number of GPs is the same?

**Dr Peters:** I cannot say whether the two elements are exactly the same, but I think that the number that you have quoted is for performers or partners—is that right?

**David Stewart:** Yes. It was the number of GP partners.

**Dr Peters:** We are seeing a trend playing out in most places of fewer partners running practices and more salaried people doing so.

11:30

**David Stewart:** I am sure that the convener will mention this—if I have read his mind correctly—but it would be good to get some accurate statistics. Obviously, I am quoting the ISD survey, which provides an independent assessment of numbers in the health service in the Highlands. If you have a different interpretation of the statistics, we need to know about that.

**The Convener:** That would be helpful.

I want to finish with a conversation about leadership in the board, but before I do, I would like to come back to maternity services in Caithness. The figures that I have seen from the Caithness health action team suggest that 90 per cent of mothers from Caithness are sent to Raigmore to give birth, and that a high proportion of those births are induced births. Those seem to be surprising levels, considering risk assessment. Can we have a response on that?

**Dr Peters:** There is individual patient care and individual patient choice. There is no issue about people being sent to Raigmore—they choose whether to do so. A specialist and a midwife are involved in a person's care when they start the journey of pregnancy. They will talk through the risks that apply to that individual's health and their individual pregnancy, and the decision is made jointly so that, under realistic medicine, there is very much a maternal preference stated. The clinician will state what action will carry the right amount of risk in that situation.

We are seeing that a lot of prospective mothers choose the safest option, which involves them going to a hospital that has, for example, a neonatal intensive care unit and other attendant services that might not otherwise be available to them.

However, a community unit is still available to prospective mothers. There are a number of community midwifery-led units in the Highlands. It is not a board decision: we have no influence on the individual conversations that take place

between a consultant obstetrician and two parents who want to safeguard the wellbeing of their child.

**David Park:** I can add some numbers to that. We have other community maternity units across NHS Highland—in Argyll and Bute, as well as in Skye and Fort William. Typically, they handle 10 per cent to 12 per cent of local births. The model in Caithness is similar to what we see in the other community maternity hubs.

**The Convener:** That is helpful.

**Iain Stewart:** We have great facilities and midwives in all the community maternity units in all the areas—not only in Raigmore. If a mother is on a green pathway, we would say that they would absolutely be cared for very well in the maternity unit in Caithness general hospital or one of the other maternity units.

**Emma Harper:** Sometimes, in the case of a person's first child, an intervention in Raigmore is required. However, if a pregnant woman has already had a safe delivery of their first child—in other words, she is para 2—they might choose to have a community midwife led delivery. It all depends on the risk assessment, and on whether it is their first child or a subsequent child. Is that correct?

**Dr Peters:** The choice is offered; ultimately, it is for the mother and the clinician to come to a decision on the preferred option. It is very much to do with preference, as well as risk management.

**The Convener:** Leadership has been a recurrent theme in our engagement with health boards and IJBs, and in our budget reports on integration and so on. I will cast back to the point at which you were looking at finance and planning ahead. You talked about the importance of PWC coming in to provide expertise. Could you comment on that? Does that reflect a lack of capacity in the board? Is there an issue about the kind of expertise that you need in order to provide the leadership that NHS Highland needs?

**Professor Robertson:** That was in recognition of the fact that we were escalated to level 4 and required considerable external input. Iain Stewart referred to the recent appointments that have been made since he and I joined the board—the new director of communications, the new director of HR and the on-going recruitment of a director of finance. Those are measures to address deficiencies in the organisation. When I joined the organisation, I was taken aback that we had a part-time HR director for an organisation of 10,500 employees. That has been addressed.

However, we recognise that we cannot, especially given the absence of a finance director, address the financial turnaround without external support. We were grateful to the Scottish Government for the support that it offered through PWC and the establishment of the programme management office. A turnaround director was also installed for six months. All that has been helpful in addressing the financial turnaround issues.

**Edward Mountain:** I welcome the fact that Boyd Robertson and Iain Stewart have worked particularly hard to cultivate a relationship with MSPs.

I have two questions for Boyd Robertson. First, if you look at an organisation, you look at how the management is going. The string of resignations of board directors indicated to everyone outside the board that there was a problem. It was interesting that the executive directors on the board wrote a letter to the non-executive directors to tell them that there was no problem with the chairman and the chief executive, which was contrary to what the non-executive board members felt. Should the problem within the board have been picked up earlier? The red flag was there, in that so many non-executive board members had stepped down.

**Professor Robertson:** I will not comment directly on the situation before I came into post on 1 March, except to observe that I noticed an exceptional level of departures from the board in 2017. That was part of the failure properly to grapple with the bullying issue within the board at that time. Since joining the board in March, I have attempted to set a new tone and tenor in the organisation, as has Iain Stewart, as chief executive. That is important. We are about to appoint a vice-chair: we are just waiting for approval for that from the cabinet secretary. Going forward, that will be an important part of the organisation.

On the governance front, there is still a lot to be done. We are working extensively on that. John Brown, as chair of NHS Greater Glasgow and Clyde, is helpful in that regard. He is mentoring me in my role, which is helpful to me. His good "Corporate Governance in NHS Highland" report, based on his analysis of governance in the area, showed that there were considerable deficiencies in practice at that time, which we are in the process of addressing. We have had a series of board workshops, in which we have engaged NHS Education for Scotland, on finance, risk registers and, recently, on board roles and responsibilities and team building. We have had a workshop on induction and, last week, one on the Sturrock report, which was chaired by John Deffenbaugh of NHS National Services Scotland. We are on a journey to address the deficiencies that we inherited.

**Edward Mountain:** The second question is easier, because you partly answered it. Anyone looking from the outside who saw the level of

resignations of board members would not only have red-flagged the issue, but would have gone straight in and found out what the problem was.

Non-executive board members can and do bring a huge amount to the organisation. Will you set up annual reviews to allow those non-executive board members to feed back to the executive members and allow them to say how they feel the board is progressing? If there is no such openness, I am not sure that they will be able to deliver the full potential that they have to offer.

**Professor Robertson:** We are considering a range of actions in that regard. For instance, each non-executive member has teamed up with an executive member of the board to shadow their role, which enables two-way information sharing and dialogue. We also have annual appraisals of board members, which gives them an opportunity to tell me how they feel, and we have the iMatter survey, which was mentioned earlier.

Other instruments are planned, such as having the chairs of all of our committees meet as a group, which practice has been in abeyance for a period of time. We are looking at a range of measures to address that situation.

**The Convener:** I thank all our witnesses for their attendance this morning. There are a number of items on which you have agreed to provide further written evidence. I will not rehearse them all, as I am sure that you are all fully aware of what they are. I look forward to receiving that evidence.

11:41

*Meeting continued in private until 11:57.*

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