OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 26 November 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 26 November 2019

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HEALTH AND SPORT COMMITTEE
28th 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:

Grant Archibald (NHS Tayside)
Lorna Birse-Stewart (NHS Tayside)
Stuart Lyall (NHS Tayside)
Gordon Paterson (Perth and Kinross Integration Joint Board)
Peter Stonebridge (NHS Tayside)
Lorna Wiggin (NHS Tayside)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Perth and Kinross Council

Scottish Parliament

Health and Sport Committee

Tuesday 26 November 2019

[The Convener opened the meeting in private at 09:40]

09:45

Meeting suspended until 10:00 and continued in public thereafter.

Scrutiny of NHS Boards (NHS Tayside)

The Convener (Lewis Macdonald): Good morning and welcome to the 28th meeting in 2019 of the Health and Sport Committee. I am delighted that the committee is meeting in Perth this morning. We have enjoyed fantastic hospitality in the city both this morning and yesterday evening, for which I thank all those who have been involved.

We have received apologies from Sandra White, Alex Cole-Hamilton, George Adam and David Torrance. I am delighted that our other members are here with us today.

I ask everyone in the room to make sure that mobile phones are switched off or to silent mode. Although it is acceptable to use mobile devices for social media purposes, please do not take photographs or record our proceedings. As you will observe, proceedings are being filmed and recorded by Parliament staff.

Our main agenda item is to take evidence as part of the committee's on-going programme of scrutiny of health boards. We have had the opportunity to hear from a number of health boards across Scotland, and today we are in Tayside in order to take evidence from NHS Tayside. I am delighted to welcome from NHS Tayside Grant Archibald, who is the chief executive; Lorna Birse-Stewart, who is the vice chair; Lorna Wiggin, who is the chief officer for acute services; Peter Stonebridge, who is the medical director; Stuart Lyall, who is the interim director of finance. I also welcome Gordon Paterson, who is the chief officer of Perth and Kinross integration joint board. Welcome to you all.

As is usual at our committee meetings, questions and answers should be directed through the chair, and I will call members in turn to pursue lines of inquiry.

I welcome Grant Archibald as the new chief executive, and I ask him to give us an indication of his vision for NHS Tayside under his leadership.

Grant Archibald (NHS Tayside): Thank you very much indeed for allowing me to do that. I commenced in NHS Tayside 11 months ago. I am a Dundonian—a dangerous thing to say in Perth—and I am very proud to be back in Tayside.

Tayside has for many years enjoyed a reputation as an excellent health board. We have had some challenges recently, so we are keen to demonstrate today the progress that we are making.

As we integrate with our colleagues in councils, there are three pillars on which I, the chair and the board are seeking to build the future of healthcare services in Tayside: clinical governance, staff governance and financial governance. Those three elements are important for us because the patient, the relative and the citizen are at the heart of that.

We seek to establish that our clinical services are excellent, safe, appropriate to our population, and provided in the right environments, which might not always be hospitals or general practice surgeries, but out in communities.

On our staff governance, we believe that NHS Tayside is an excellent place to work. It has many attractions and many major achievements to its name, and we want to ensure that when we say that staff are our most valuable resource, we mean it. We have 14,000 staff who work incredibly hard for us. Our job is to lead and guide them to get even more for our patients, in better ways and through redesign. That will be a key component of our work as we go forward. We always want staff to feel valued. It is important that we embrace partnership working with our trade union colleagues, and that we reach out and provide services that mean that Tayside is a very attractive place to work, based on its reputation and its commitment to its employees.

Our financial governance is also important to us. It is essential that we spend wisely the money that has come from the public purse. We know the challenges that all organisations face in so doing, but a pound in the health service is the same as the pound in everyone's pocket: it can be spent only once, and one should be spending only what one has.

One of the major challenges that I accepted in coming back to Tayside was that we would balance the budget by the end of a three-year period. We will report today on our good progress in that regard. There remains a continued challenge, but we are up for that challenge.

It is important that we have developed a model in Tayside of clinically led and management-enabled services. We are working with our clinical colleagues to find the best design for services, to make those as efficient as possible and therefore to deliver on the reasonable expectation of the Government that within that three-year period we will report a balanced budget.

The Convener: Thank you very much. I will follow that up with questions on the issues that you highlighted of clinical and staff governance—leadership, essentially. I know that the model that you have proposed for the board includes a number of new leadership posts of some importance. Can you tell us where you are on recruiting for those leadership posts and how much progress you are making?

Grant Archibald: Certainly. There has been quite a reorganisation in Tayside in the past two years. The board membership and, indeed, some of the management membership are unrecognisable from what they were two years ago, so we have had a big changeover. One of the reviews that we conducted since I came into post was to ensure that we had the right people in the right places and that we had roles that were relevant to the challenges we face. Therefore, I made certain decisions about posts that we should develop.

When I arrived, we had an interim medical director, who is now the successful appointee to the medical director post—I am delighted to welcome Peter Stonebridge, who is sitting on my right, to that post. We currently have an interim nurse director, due to a retirement, but we have arrangements for that post to be filled from 6 January. I am delighted to say that we have recruited somebody who is already a nurse director in another part of the health service.

As for other posts, Stuart Lyall, who is sitting to my left, is acting as the interim director of finance. One of the recommendations of the auditor was that we should have a full-time director of finance—we had been sharing ours with Grampian. We have put the post in place and are interviewing for it on 5 and 6 December.

There are two other posts to which I will draw attention. One is the deputy chief executive post that had previously been amalgamated with the post of medical director. I thought that that was too challenging and too broad a responsibility, and I shall explain why.

The other is a director of facilities to look after our estate. We are the fourth-biggest board in Scotland and the third-biggest property holder. We have properties such as Ninewells, which is now 50 years old, and properties at Auchterarder and Pitlochry. We have a very mixed estate and it is essential, in our redesign of services, that we also redesign that estate. The deputy chief executive post is key, because we are going to transform Tayside in the next three years in a way that will take services beyond hospital walls, so that only those who require to come to hospital will do so. We are going to optimise and become an upper quintile or upper quartile performer in terms of delivery of our services. We are going to work closely not only with the integration joint boards, of which there are three in Tayside, but with our councils and our colleagues beyond to redesign services across the board. I thought that the deputy chief executive was a key role and that such a level of transformation required a dedicated person to lead that team.

I have some experience of that. I recently returned from 30 years working in the central belt. I opened University hospital Wishaw and the Royal infirmary of Edinburgh, and I was the chief officer responsible for the redesign of services to be located in the Queen Elizabeth university hospital in Glasgow, which was a massive undertaking. I have experience in this sphere, as do colleagues around the table, but we recognise that we need to bring some additional resource to the table and that is what we are doing.

Brian Whittle (South Scotland) (Con): Good morning, panel. You will be aware that we took evidence yesterday evening from members of the public and from clinicians. Their very strongly held view, if I can put it like that, was that the make-up of the non-executive position does not reflect the experience that they think is required to deliver the treatments they are looking for, especially around mental health. They also felt that the age demographic did not reflect what would be needed from a non-executive position. Do you care to comment on that?

Grant Archibald: Certainly, I will comment and the chair may wish to also. We have recruited an almost entirely new board: we have only two board members who served in the previous board of early last year.

We have made an effort to recruit people who not only are interested in and committed to the health and wellbeing of the citizens of Tayside, but can bring a range of skills to the board. We are also seeking to recruit people with additional financial skills to serve on our audit committee and our other committees; we have had some assistance from another board pro tempore to support us in that regard.

In respect of the demographic, there is broad experience across the board. There are people who have worked in charities and universities and in the community, and people who were previously staff members of NHS Tayside working as radiographers and so on. Of course, the make-up

of any board depends on who puts themselves forward, and the mix of people on our board reflects that.

I must confess that this is the first time that the matter has been raised with me. With the convener's forbearance, I am content for us to go away and reflect on that further. As the committee will know, I do not appoint the board members, but we are keen to respond to those who come forward.

I can say candidly, having worked with the boards of five different health boards across Scotland, that I find that the make-up of our board, from the elected officials that make up the council representation to those who come through the other designated routes, reflects quite a broad spectrum. The members bring a lot of skills to the table, and I have found them to be both supportive and critical friends throughout my experience thus far. My chair might want to say something in that regard.

The Convener: Thank you. We will revert to you with some further requests for information at the end of the meeting, but you should feel free to add any reflections afterwards.

Lorna Birse-Stewart (NHS Tayside): There has been a significant turnover in the board, to which the chief executive just referred. The demographic runs from the age of about 34 right the way through to older members. The appointments to the board are public appointments, and the members are people who have come through the process.

We recently created a new public health committee with a non-executive chair and vice-chair who have significant experience around the mental health agenda. We have a diverse board, and we now have a good skills mix. As a caveat to that, we want to create two additional posts to which we would expect to appoint people by the middle of January; the process is currently on-going. I do not know what the age demographic is in that regard, but we will note the points that have been raised and take them forward.

The Convener: It has been drawn to the committee's attention that leadership has been an issue. The appointment of Peter Stonebridge to the permanent post of medical director is clearly significant. However, do you have concerns around the need to strengthen clinical leadership in the board in various areas such as oncology, psychiatry and so on?

Grant Archibald: I am hugely impressed by the clinical body that I know in NHS Tayside—again, that is in the context of my experience elsewhere. The clinical team is a young and enthusiastic group of people who are very much committed to taking Tayside forward and keen to earn the reputation that we think their hard efforts deserve.

There is an excellent associate medical director who has stepped up in our primary care services. In the area of mental health, we had an incumbent in post who stepped down, and in recent months we have appointed a new temporary AMD called Mike Winter. He was appointed because I had worked with him previously in NHS Lothian, and I knew that he had an excellent record in both Lothian and Lanarkshire in helping to turn around mental health services that seemed to be in difficulty. He had in fact retired, but he has come back to work with us on a temporary basis, and he is totally committed to supporting and taking forward the mental health agenda. His ideas and commitment, and his engineering of relationships with different people, have already given me huge enthusiasm, and I believe that we have identified the right person to do that job.

As recently as yesterday, we had a meeting with a Scottish Government oversight group. Mike Winter was there with us, and he would have been here today if the panel had been bigger. He has excellent skills, and I am therefore very confident that we are now on the right track and that we have the right expertise applied in that area.

The Convener: Is that a permanent or an interim appointment?

Grant Archibald: It is an interim appointment. We were keen to get Mike Winter, and he will bring his skills and take us through a series of stages, but we will be looking for a permanent appointment in due course.

Peter Stonebridge has vast experience as a vascular surgeon working with the University of Dundee and in commercial enterprise. He has been hugely supportive of me over the period, and he carries the support of the clinical body. He has been an excellent appointment to the board.

10:15

The Convener: I do not know whether Peter Stonebridge wants to add anything in relation to the clinical leadership team with whom he is working.

Peter Stonebridge (NHS Tayside): Fundamentally, the health service depends on everybody working together and being equally valued. It is my observation that where people work together, we can make big changes. We have tried to make the team work. Watching our operational leadership team at work warms the cockles of my heart. We have relatively unique circumstances, in which there are excited finance people working with excited clinicians and excited managers to try to make things better.

Fundamentally, we are all here to help people to help people. If we can help as many people as we can by working together, that is exactly what we should be doing.

The Convener: The other area that was highlighted at the outset was financial governance and leadership. David Stewart will ask questions on that.

David Stewart (Highlands and Islands) (Lab): I welcome the panel. As the convener said, I will ask about financial sustainability. I note the points that the chief officer made earlier about financial governance being a crucial part of the board's new strategy.

The panel will be aware that the Auditor General for Scotland recently expressed some concerns about the lack of detail in the savings and transformation plan. Can you tell me in detail how you plan to resolve that issue?

Grant Archibald: I will make a few comments before I hand over to my colleague Stuart Lyall. In the current year, we are confident of the figures that we are delivering and confident that we are on a trajectory to hit the target that the Government set for us. That is important. I am, along with Stuart Lyall and other colleagues, engaging in discussions on what years 2 and 3 of our financial recovery plan look like.

At the heart of the plan is transforming Tayside; I will take a moment to explain that. In transforming Tayside, we will be making incremental changes and achieving productivity gains, but we also want to transform how services work. For too many years, Tayside has been providing services at a cost that cannot be afforded, and we therefore need to radically review that provision.

We currently have a total of 97 schemes proposed by clinicians for how health services could be redesigned. I have, along with Stuart Lyall and other senior members of the team, including Peter Stonebridge, created what is effectively an assessment caucus—almost a "Dragon's Den"—in which ideas are brought forward and tested. They are tested against criteria such as whether they will deliver savings in year 1 or year 2, what benefits they will deliver for patients and how we will see those benefits, and how we can be encouraged that they will allow us to achieve the targets in the financial plan that we need to achieve.

In our detailed proposals for next year, we say that we will achieve £7 million-worth of savings through the redesign programme. We are currently at the stage of working through the array of proposed schemes to identify those that will deliver quickly and those that might take longer. We have a whole criteria matrix against which we can assess the schemes. We are running the service not as a business, but in a more business-like way, which raises issues around the invest-to-save approach.

Colleagues will be aware of social prescribing. I know that members are interested in diabetes, not least the increase in type 2 diabetes. Type 2 diabetes is avoidable and reversible, so if we can get people exercising—by subsidising gyms, perhaps—that is far better than giving them a pill. We are engaging with social prescribing, but in order to do that we need to make certain investments to set up new services, so we need to get a return of greater value. We are testing the whole environment in that regard.

Those are the frameworks in which we are working. Stuart Lyall can give you some more detail, if that is acceptable to the committee.

Stuart Lyall (NHS Tayside): I will look back at the previous financial year and comment on the savings issue. In the previous financial year, we overdelivered on our savings plan. In the current financial year, as things stand, we have identified 98 per cent of our savings plan and there is a high degree of confidence that we will overdeliver again.

I do not have concerns about our ability to deliver savings. I think that the approach that we are taking with the clinical leadership model and the engagement that we have around that is fundamental to the delivery of savings through the transforming Tayside programme. We have had a few successes in that regard, which I would expect to continue. They are recurring successes, which will give us sustainability. For example, our spend on GP prescribing is more than £2 million lower than it was in previous years. That is the result of a whole-system effort, and it is sustainable.

We have also worked with clinician colleagues as they have set up good governance models for medicines management groups within each of the clinical care groups. In that way, they have managed to stabilise the spend on secondary care drugs—the spend is the same this year as it was last year, against a background of costs increasing by between 7 per cent and 10 per cent nationally.

There are good examples of how that leadership is paying dividends. For example, on unscheduled care performance, investment in the right areas in the community and in social care is taking costs out of the hospital system. Our winter plan last year was successful and has been held up by Government as a good model that other boards could replicate.

The savings that we are making are sustainable. Next year, we can implement elements of the transforming Tayside programme, and we will

continue the good work that has been done over the past 18 months.

David Stewart: What we are hearing is positive. However, I think that the big picture concerns a question that the public is also asking. At the end of the three-year period, will the board be able to break even without use of brokerage?

Grant Archibald: Our commitment is to break even without brokerage at the end of the three-year period. That is one of the reasons why I applied for the job, and I took it on the understanding that that was absolutely a responsibility that I and my board had to carry.

The transforming Tayside programme is a metric for us taking that forward. However, I am aware that, through the Public Audit and Post-legislative Scrutiny Committee and others, the Parliament has had previous representations from Tayside about budgets. Let us be clear: the levels of granularity that are required to put us on a better footing are being put into place right now. As Stuart Lyall says, one of the things that we wanted to do—as I am sure that you understand—was secure year 1. We have invested a lot of time and effort in doing that during the first part of this year and the first part of my tenure.

We are absolutely focused on the fact that we must have the levels of granularity that demonstrate our ability to assess and, indeed, review our steps towards achieving the targets for year 2 and towards breaking even by year 3.

David Stewart: That is good to hear. You will know that in our inquiry, we have looked at the bulk of the boards in Scotland. There are common denominators among boards, particularly those that have the rural element, such as yours. Some questions are being asked about whether some boards are financially sustainable at all.

I want to raise the issue of brokerage in particular—for the benefit of those who are watching in the public gallery, I say that brokerage is financial help from Government. I just want to confirm that I have the facts right. My understanding is that you have had brokerage for seven years. You have received £67.8 million in brokerage, you have repaid £4.3 million and there has been no repayment since 2014. Is that correct?

Grant Archibald: Those figures are correct. Stuart Lyall might want to comment further.

David Stewart: Are those figures correct, Mr Lyall?

Stuart Lyall: They are.

David Stewart: As you know, there is some debate about whether current brokerage is to be repaid at all—the committee has pursued that question. For the record—I want to ensure that the committee is clear about this, because there is genuine confusion—what is your understanding of whether brokerage that you have received or been promised is to be repaid? Obviously, you have repaid only a small percentage of the £67.8 million. Do you expect to repay the rest of that, or is the assumption for financial sustainability based on the fact that you will not have to repay that brokerage? Is that part of the calculation around breaking even over the three-year period?

Grant Archibald: The previous brokerage was written off—or, rather, it was underwritten. The challenge that we face over the three years is that, as you will see from our figures, we need brokerage until we get to the end of that period. As you have heard in previous meetings of this committee, the period over which that brokerage would need to be repaid is yet to be established.

The first achievement that we need to deliver is to break even in real terms. Then, the issue of the brokerage that allowed us to put ourselves in order will be discussed in detail.

David Stewart: To be clear, and to ensure that I have understood this correctly, you are saying that the bulk of that outstanding brokerage will not be repaid to the Scottish Government, because you received it on that basis.

Grant Archibald: That is true.

David Stewart: At the end of the three-year period, you would expect to break even without any further brokerage.

Grant Archibald: Yes. At the end of the three-year period, we will be financially solvent, and there will be a project to deal with the brokerage that has allowed us to get there. Discussion is on-going on what happens to us and to other boards in similar circumstances and on whether the amount will be repaid over a certain period or to what the arrangements are. I am sorry that I do not have the details.

David Stewart: I think I have the general thrust of it.

Following the various questions that I have asked on brokerage and the work that you are doing to ensure that there are savings in the future, would you say that NHS Tayside is financially sustainable as a board?

Grant Archibald: Yes. There is a focus for me here, if you do not mind me explaining. I, or we, get £950 million to run health services in Tayside—it is almost a £1 billion industry. We can focus on savings—I understand the need to do that—but the real challenge for me and my team is how to spend that money wisely and how to govern ourselves in the same way that other

organisations in the public sector do and ensure that we break even.

I entirely understand that there is a challenge with the track record of NHS Tayside. I am trying to articulate that, by putting new mechanisms, new ways of working, new governance arrangements, and new levels of granularity and challenge into the system, we are looking, with our colleagues in the redesign of services, to ensure that we break even.

The Convener: Audit Scotland also commented on the overspend in relation to Perth and Kinross IJB. What is the position with IJB overspend in Tayside? How is that addressed? Is it the responsibility of the individual IJB, or is it something that NHS Tayside takes forward?

Grant Archibald: I will start and Gordon Paterson will provide amplification.

For those who do not know, we have three IJBs in Tayside: Dundee city, Angus, and Perth and Kinross. We have excellent relationships with the three council chief executives, and I meet them on a monthly basis. We meet not only as chief executives but as IJB chief officers. We do that because we have a common concern. The patient in Pitlochry, Perth or Dundee does not really care where services start and stop or who runs them—they just want to know that they are cared for. Our obligation is to make those services work on an interdigitated basis, which means that they are safe and appropriate. We also need to consider their affordability, and we confront that challenge in the same way that we confront the challenge for directly managed services.

We have meetings with the three councils and the three IJBs regarding our arrangements, and we explore with them where we are financially. You are right that there is pressure in the system at the moment—that has been identified through our arrangements with the integration joint boards. There is pressure in Perth, and I am sure that Gordon Paterson will say a bit more about that.

NHS Tayside, the councils and the IJBs have a commitment to work together. We have a common concern and a common commitment. How can we best help one another to make the best use of resources and ensure that resources work seamlessly, do not collide and are not unhelpfully duplicated?

I ask Gordon Paterson to give some further comment.

Gordon Paterson (Perth and Kinross Integration Joint Board): It is important to frame this in the context of our commitment to ensuring good financial stewardship. The current position is that Dundee and Perth and Kinross IJBs have projected overspends. We face significant challenges with service demand and I think that the overspends are a reflection of our commitment to spend the right money in the right places. We consistently deliver good performance in achieving the national outcome indicators.

10:30

The demands that we face in relation to the significant growth in the number of older people, the prevalence of dementia and the longevity of people with learning disabilities, which is a complex issue, are compounded by the rurality of parts of Perth and Kinross and Angus, and the levels of deprivation in Dundee.

That all results in the projected overspend in Perth and Kinross. Should that happen, the year-end arrangements will involve the council taking responsibility for any overspend on the social care side of the budget, while the national health service will take responsibility for overspends on health services. A different risk-sharing agreement exists in Dundee and Angus. For example, two thirds of Dundee's total overspend will be absorbed by the NHS, regardless of its source, and approximately a third by the council. The ambition in Perth and Kinross is to move to a risk-sharing agreement consistent with those of the other two partnerships.

However, the focus of our activity and of our collective endeavour is on how we deliver financial balance and achieve financial recovery. Both Dundee and Perth and Kinross IJBs have introduced financial recovery plans that colleagues on the health board and the IJB approved. We are seeking to introduce measures that will, we hope, enable us to deliver financial balance. That will prove challenging and is about how we can transform some of what we do. Some of that is perhaps more of a medium-term ambition; in the meantime, we are looking at activity, service reviews, how we can do things differently and how we can make the best use of our available resources in order to deliver balance.

The Convener: One of the committee's findings across the board is that the progress of integration varies from one area to another. You are telling us that it is very variable, or at least variable, within Tayside. Do you accept that there is an issue around the separate identities and separate lines of accountability that remain when funding comes from the health board on one hand and from the local authorities on the other? The arrangements do not sound integrated at all.

Grant Archibald: I can give a health board perspective and Gordon Paterson can then give his view.

I have worked in the health service for 35 years. For all that time, we have talked about working in

a more integrated way, and about more care that is more reflective of patients' needs being delivered more locally. We have tried very hard. The past three years show a level of commitment from the Government and from the health service and other agencies to make the integration process far more real and demonstrable. The creation of the integration joint boards and health and social care partnerships is a major step forward in that regard.

However, we are trailblazing—nobody else does things quite like we do. As we go forward with the integration of different parts of existing networks in Tayside and across Scotland, there is a learning and development process. Councils are different from health boards, and at times they have different drivers and challenges. That said, we are maturing. The process has far clearer engagement and there is a far better understanding of routes for patients. We are getting into those discussions and asking how the patient's journey—for want of a better phrase—starts and ends, and how we can work collaboratively to ensure that understanding.

You are entirely right to say that there is variability in the risk-sharing agreements that were set up in Tayside some years ago. That is a technical matter, on which we have on-going discussions with our colleagues in Perth and Kinross. The real benefit is that, within Tayside, we are of a size that allows me to have joined-up discussions with the three council chief executives and with the IJBs about our aspirations.

To give the committee some further insight, let me give the example—which some might see as a negative issue—of the Dundee drugs commission, which reported a series of challenges regarding our provision of services in Dundee. People will be aware of the drug problem that has been identified in the city and of the number of deaths among drug users. On the back of the commission's work, we have created a body—involving the third sector, the police, the fire and ambulance services, the health board and the council—that looks at the whole experience of those in need and their families. I can see that real developments are arising from that already.

Those are the sort of positive engagements that we need to have and the sort of examples that we need to develop. In developing them, we find better ways to make ourselves work together, and they provide real examples that we can share with the public and others to demonstrate not just that this is work in progress, but that it is something that is going to achieve change.

There are aspects of integration that are about technical arrangements and risk sharing. I think that the bigger and better challenge is about how we make a service involving multiple agencies appear seamless to the users, and how we make it efficient.

Gordon Paterson may want to say something more.

Gordon Paterson: Perhaps I will say not much more, convener.

The point that we are at on our integration journey is perhaps a reflection of where we have come from. There is some variability in Tayside, and perhaps in Perth and Kinross we have not achieved the same degree of integration or level of maturity that is evident elsewhere. That is the challenge for me as a relatively new chief officer with a new chief executive on the council and a new chief executive in NHS Tayside.

That variability in no way reflects a lack of ambition for us to drive forward the pace of integration, to achieve synergies, to join up services and to ensure that, as Grant Archibald said, patients, citizens and service users are not able to detect whether something is a council service, a health service or an IJB service.

We have a shared ambition and the conditions to drive forward integration much more effectively. The three partnerships in Tayside learn from one another. Equally, we are open to looking at, borrowing or stealing ideas that are emerging across Scotland through the work of the IJBs and the health and social care partnerships, with which we connect regularly.

The Convener: In making that change and in seeking to progress integration and make it as user friendly as possible, how are staff-side partners and the public involved? Is the process simply driven from above or from the centre, or are there ways in which you engage with the workforce and the public?

Grant Archibald: I have said that we have 14,000 health staff who are incredibly hard working—indeed, they are all working hard today. Part of our challenge is to marshal that effort into directed action, so that we achieve the best. Our ambition is for everybody to go home at night feeling that they got out of their job what they put into it.

Our partnership working is key to that relationship. We have well-developed partnership relations inside NHS Tayside. We have an employee director who is a member of the trade union and sits on the board. That employee director sits in on all my senior meetings and helps to discuss the agenda. Partnership working exists at all levels in NHS Tayside. In our commitment to going forward, I am quite clear: it is far better to walk alongside or to lead 14,000 people than to try to push them.

In our relationships with councils, we are again engaging on a partnership basis. There are challenges—we have challenges in some of our services at the moment—but we are working our way through them, and we continue to engage with our staff partners on understanding where those challenges are. We have an area partnership forum, which involves all the staff-side representatives from across Tayside; the three IJB leads also sit on that forum.

The Convener: I have a similar question for Gordon Paterson. How does the IJB engage with staff, given that they come from two different employment backgrounds? Also, how do you work with the public to deliver services?

Gordon Paterson: Each of the health and social care partnerships has a local partnership forum, with staff representatives and trade union representatives who represent the council staff. We have joint forums where we discuss change, new service models and any issues that have arisen. Health and safety, the staff survey and iMatter are all standing items, and they are regularly discussed. We also feed into the area partnership forum.

In recent weeks, we have established a partnership forum across Tayside to look at learning disability and mental health services. We have had a couple of meetings of that forum.

On consultation and engagement, it is important to state that when the health and social care partnerships bring forward proposals on service redesign or are pulling together strategic plans on care groups, we work very closely with the third sector. We also engage with communities and connect with community councils. We seek to walk that path with people who will be affected by any of the changes that we make.

The Convener: I am sure that we will come back to a more substantial discussion on mental health. I will ask a simple technical question. Where does responsibility lie for mental health in-patients? Does it lie with NHS Tayside or the hosting IJB?

Grant Archibald: My colleagues on the board and I take ownership of the care of patients. That is one of our responsibilities. Ultimately, the responsibility to deliver health care to anybody in Tayside lies with me, as the accountable officer; in clinical terms, it also lies with Peter Stonebridge. Through the arrangement for hosting of services, we try to create environments where there could be co-ownership of services; we also try to make services work more collaboratively. The arrangement in Tayside—it is a slightly different model from where I have worked elsewhere—involves a delegation of responsibility for mental health services.

Each of the individual IJBs—in Dundee, Angus, and Perth and Kinross—deals with community services. In-patient services are delegated to the Perth and Kinross partnership, which commissions and leads those services. It is clear that we need to work collaboratively, and that is part of the process of my bringing in Mike Winter and others. We recognise—we will no doubt get into this, as you said, convener—that there are challenges in mental health in Tayside that have been there for some time. We are keen to work together to meet those challenges. Ultimately, I am responsible, with Peter Stonebridge, for those services, but responsibility for the hosting arrangements resides with Gordon Paterson's IJB.

Emma Harper (South Scotland) (SNP): I have a few questions about the operating model. The 2018-19 audit report for NHS Tayside states that the board has an

"expensive operating model compared to other NHS boards ... staffing numbers per head of population are higher in NHS Tayside than in other boards. Furthermore, Tayside's average in-patient costs have been more expensive than other boards. The total prescribing cost per weighted patient within NHS Tayside has been higher than average, due to a combination of more items per patient and more expensive items."

As someone who was a nurse for 30 years, I understand the critical nature of appropriate staffing, whether in acute care, the community or primary care. Are the staffing numbers higher among clinicians or in other areas? Is there a plan to address that? You have talked a bit about exercise and social prescribing, which would replace prescribing pills for type 2 diabetes. Are you exploring the opportunities for cost reduction in staffing, in-patient services and medicines?

Grant Archibald: I will respond first. My colleagues, Peter Stonebridge and Lorna Birse-Stewart, might want to comment on acute services, and Stuart Lyall might want to comment on the finances.

I am a great believer in making comparisons. Since I came to NHS Tayside, I have looked at our board and tried to understand our cost per capita compared to that in the other boards in Scotland. We are not so different that we should have differentiation. We have established which boards are in the upper quartile, or upper quintile, of performance and where we are relative to those boards on length of stay, theatre start and finish times, number of cases on theatre lists and new to return patient ratios in out-patients. In that regard, we have demonstrated that the number of times we bring people back to certain out-patient clinics is very different from what happens in the rest of Scotland—at least, it is different from what happens in the best in Scotland. Therefore, on that granular basis—which takes us back to Mr Stewart's point—we are getting into all those

elements to understand what is driving cost, why we are different and whether there is a good reason for that. If there is not a good reason for it, we expect to correct our delivery.

10:45

Having worked in five NHS boards, I am quite shameless: I think that we should look over each other's shoulders at each other's jotters. If people are performing better in any other part of Scotland, we go to see them. There is a lot of interest in looking at international models, but I have encouraged my colleagues to look at Fife rather than Finland, because we have far more in common with Fife, and if they are doing better than us, we only need to drive across the Tay bridge to find out why. We are taking it down to that granular level. When we talk about redesign, we talk about why our models should be different, what the best models are and what the most efficient models are. That is the process that we are undergoing at the moment.

Our staffing model is more expensive, but the standardised nursing staffing model now dictates what we will be using in wards and departments, which will be standard across Scotland.

In relation to our medical staffing model, we have some issues—as do other boards—with utilising locum staff, not least in our mental health services, where they cost a very significant amount. We are considering whether there is anything that we can redesign to change that.

I know that the committee wants to look at mental health later, but we have 14 consultant vacancies in mental health at the moment. Recruiting psychiatrists is a challenge across Scotland; I am not confident that we are going to be able to get those people. In their absence, we have to use locums. I think that locums are a poor use of money, because they are expensive and they are not embedded in the service.

Mike Winter, whom I have mentioned, has identified that we should transfer some of the resources from 10 of those posts to create 10 nurse consultant posts, recruit into those, and redesign the model of care.

Those are examples of what we are developing. It is about not only the numbers in the workforce, but changing how the workforce works.

At this point, I want to applaud our workforce, if you do not mind, convener. We have one of the lowest sickness absence rates in Scotland—it is below the national average. We have a vacancy rate of only 5 per cent, but the vacancies are in key areas, and recruiting to those key areas is difficult. We have a lot of people who are working enormously hard, so when we hear it said that we have an expensive model, I know that that is a challenge to them. Our commitment is to work alongside them to redesign more affordable and different models, not so that we are the same as others, but so that we are in the vanguard.

I turn to some of the decisions that the board made just three or four months after I came in. We have a differentiated model now for urology, which allows a one-stop shop service—sorry, that is a bit of jargon: it means that, when someone turns up at out-patients, they get everything done on the one day, rather than having to come back for several appointments. That service is up and running at Perth royal infirmary as we speak—it is just down the road from here.

We have looked at a separated model around orthopaedics. I was asked about consultation with the public: we have gone out to the public on those plans, and I believe that we have received 375 comments.

We are working on a thrombectomy model, with patients bypassing Perth to get to the excellent established service in Ninewells, which enables them to return home. That is a redesigned model. We are also looking at completely new models, including for thrombectomy. We have just secured £650,000 from the Scottish Government to allow us to progress that.

We are looking at new models and at developing different services, and we are doing that with our staff. However, we also understand that we need to become affordable. We explore that commitment whenever we engage with partnership services, so we know that our partners are clear about that. When we work with our clinician colleagues—Peter Stonebridge will attest to this—the challenge is put again that we need to be affordable. We are absolutely committed to that.

Perhaps Peter Stonebridge or Lorna Wiggin might say something specifically about acute services.

Peter Stonebridge: Grant Archibald has been ticking off, one by one, the issues that I was going to bring up, so I was running out of things to say.

We have done an NHS Scotland resource allocation committee assessment of staffing per head of population for medical and clinical services. Essentially, just about everyone is within our statutory NRAC allocation. Those that fall outwith that tend to be in supra-regional services—dermatology is a classic example of that, and my own specialty of vascular surgery covers Fife. It is quite common for Tayside to supply services for others, so we serve a population that is greater than our book population, hence the numbers.

In terms of the model being expensive, we run out of an old hospital but we are re-adapting the way that we use our estate to be much more modern in our approach. I was going to bring up urology and the centralisation of elective orthopaedics. The dynamics of the delivery of clinical care are very different between elective services and emergency services; to get the necessary bang for your buck, you probably have to separate them significantly.

We are exploring appropriate models with everyone involved, including the patient population. In many cases, those will differ from the models that we have been running over a number of decades, and we are rapidly moving to a more advanced approach.

Lorna Wiggin (NHS Tayside): With respect to the workforce model, we are aware that there are areas within our service where we can be more productive and more efficient. For example, we have a specific programme of work to look at our use of day case units. We have had some good successes in creating new day case units, which allow patients to come in and be discharged on the day of their surgery. That has let us look at a whole new model, which then allows us to look at a different model for the workforce that supports that.

On prescribing, we have clinical leads who are very engaged in secondary care. Our interim director of finance challenged us to flatline spend in acute services this year, and the effort of all our teams has meant that we have managed to achieve that. Some very good work is being done on how we use our resources so that we can demonstrate that our workforce is appropriate and that the way that we provide services is as good as it is in the boards that are in the upper quartile. Our chief executive has challenged us to achieve that.

Emma Harper: Thank you. The issue with prescribing is to do with whether it is in-patient prescribing or primary care prescribing that is higher.

I am also interested in the length of stay of, for example, orthopaedic patients with fractured hips. Is their length of stay higher than it is in other health boards, and is that one of the issues that need to be addressed?

Grant Archibald: I will answer that question first, and then I will hand over to Stuart Lyall, who will talk about pharmacy costs.

Regarding the length of stay, we have some outliers in our surgical service, and that is part of our narrative going forward. The challenge is around using day-case units, rather than admitting patients. As we go forward, we are taking an approach of mine that I call a decimation—or top 10, top 10—approach. I receive weekly reports on the top 10 clinics that have had the poorest new patient to return patient ratio, the top 10 theatres that have had the poorest throughput, and the top 10 areas where the length of stay has been highest. Because we take that granular approach, we can go to Lorna Wiggin and her colleagues and present the evidence about the exact areas where challenges are occurring and ask them to think about what the models of care in those cases are and ask why others are doing it differently.

Scotland is not a big place—Glasgow is 90 miles away and Edinburgh is 60 miles away. That allows us to go and see other models. I am unapologetic about learning from others. We—the panel in front of you—will not always have the best ideas, but we can learn from others, and we can put those ideas into practice with the support of our colleagues. That will help us to achieve my ambition, which is to get our spending back in line with our budget. In order to do that, we need to make sure that all of our performance indicators are in the upper quartile or the upper quintile and we also need to have radically new models that will allow us to proceed in an integrated way with our colleagues in the IJBs and HSCPs, and with councils.

Stuart Lyall: NHS Tayside historically had a wide variation in its GP prescribing costs. Three years ago, we were sitting at about 9 per cent above the national average cost, which represents a high seven-figure sum of money. In the past couple of years, the level of variation has reduced to about a third of that, so there has been significant progress over the period.

The Convener: It is now about 1 per cent above average—is that correct?

Stuart Lyall: It is about 3 per cent above average, which is about one third of the 9 per cent above average that it was previously.

Stuart Lyall: That percentage variation is coming down quickly. You mentioned price and volume growth. Our price and volume growth is significantly below the national average growth this year. I expect that, by the end of the financial year, the variation will be lower still. Significant work has been done on that.

That plays out in the leadership that we have had from clinicians, including GPs. There has been a whole-system approach to that and it has been a success story in moving towards a more sustainable financial position.

On it being an expensive operating model as a whole, that is reflected in the financial gap that we carry forward from year to year, which we call the underlying recurring deficit. I assure the committee that that had reduced by 20 per cent as we entered this financial year. That demonstrates the

progress that we made in the previous financial year, and that was reflected in the Audit Scotland audit report at the end of the year. We are seeing that deficit continuing to reduce over the course of the year, so we will have a smaller financial gap as we go into the next financial year.

As we have discussed in relation to moving towards a three-year plan, by the time we reach break-even we will be in a much more financially sustainable position.

Emma Harper: Do you have a timescale for the establishment of the thrombectomy service? You will be measuring all the other areas to consider savings, so when do you expect to have numbers that show positive changes?

Lorna Wiggin: At the moment, we are training clinicians for the thrombectomy service. It is a new procedure. The plan is that it will be a phased implementation. When the first patients are treated will depend on the clinicians being competent to carry out the procedure, but it looks as though that will be early in the new year. The model will be evaluated to ensure that it is delivering what is expected. At that point, it will be rolled out across the north.

Brian Whittle: I have a quick supplementary question to Emma Harper's question on length of stay. We heard some evidence yesterday that, towards the end of treatment, when a patient could be going home or to treatment in the community, there is a lack of care in the community to allow that discharge to happen and that, therefore, patients are remaining in hospital. Is that something that you recognise?

Grant Archibald: There is an unfortunate term that is used around that, which is delayed discharge. That term disempowers patients who are in hospital and who should not be. Our absolute commitment for the future is that that should not happen.

There are a couple of things that I should reflect. We are on an improvement journey. We reduced the number of days that we call "lost" to those patients by 15 per cent in the last year. The Scottish average is about 1 per cent, so we have made a significant improvement. We have further to go. We want to ensure that our services in the community are established in a way that makes that access easy and that we look at models that are supported—it might not always be about care home placements, but could also be care supporting people at home. We have made improvements and we are on an improvement trajectory, but we still have a way to go.

All parts of the service are working extremely hard, but we need to focus on finding ways in which they can link together even better than they do at the moment. That will allow patients to have a seamless patient journey from start to finish and to find that they are in the right place at each part of that journey. We have seen improvements in our delayed discharges and we need to improve it further. That debate goes on with our IJBs and is a challenge that we set ourselves every year. We have trajectories for that.

We are better than the Scottish average in many regards. That is one benchmark, although not the only one.

Gordon Paterson: I reiterate that commitment in the IJBs to invest in new care pathways and do whatever we need to do to manage and stimulate the market to create the conditions for us to have the care-at-home services and places to enable people to be discharged from hospital as soon as it is safe for them to be discharged. For example, in 2015-16, 19,900 bed days were lost in Perth and Kinross as a result of delays, and, last year, that figure decreased to 12,200. We have made significant progress, and colleagues in Dundee and Angus are doing likewise. As Grant Archibald said, we are by no means complacent about the significant challenge that the issue brings. We recognise that, when people are ready to leave hospital, they need to leave it, because that bed could be made available for someone else and hospital is not the right place for people to be in who need to continue their recovery and rehabilitation.

11:00

Brian Whittle: There is a flipside to that. Again, we have heard evidence that, particularly for orthopaedics, the through care, such as that which includes rehabilitation and physiotherapy, is sometimes not received for up to six months after patients are discharged.

You mentioned that discharge delays have reduced significantly, from about 19,000 to about 12,000. However, as I have said, the post-operative treatment that is required is sometimes not available to the patient for up to six months after discharge. Is that reduction being forced or driven?

Gordon Paterson: No. I will ask Lorna Wiggin to pass on any details that she has on waiting times for some of those services. However, from the perspective of the IJBs and the health and social care partnership, I can say that we are in and around the hospital environment participating in multidisciplinary discussions about when someone is medically and clinically fit for discharge. That then initiates interventions, be that a home care service or a nurse service, and, critically, assessment by occupational therapists or physiotherapists and the provision of services at the point of discharge.

I am not aware of significant delays in rehabilitative services. We can look into that, and provide further information.

Lorna Wiggin: I am not aware of that being an issue; the matter has never been raised with us. I would want to take away the issue of rehab for orthopaedic patients post-discharge and identify what other information we can provide to the committee.

The Convener: Thank you very much. You mentioned that, when you arrived and looked at the operating model, you were struck by the fact that in-patient mental health services for the whole Tayside region are delegated to one IJB, which is unusual, at the very least, if not unique. Earlier, you talked about redesign of structures. Are you looking at that approach when considering redesign?

Grant Archibald: The model was certainly different from ones that I had seen elsewhere. That being said, form follows function. If we can demonstrate that it can work in that environment, we should take that approach. If we think that that structure would in any way impede the efforts that I, Gordon Paterson and others are seeking to make in improving mental health services, we would look at it again. At the moment, we are concentrating on how we make the model of medical care and support care in the community work. Beyond that, if we find that any of our structures are an impediment to progress, we would be honest enough to have that debate with the IJBs and, indeed, the Government.

Miles Briggs (Lothian) (Con): I will ask questions about oncology in Tayside. Earlier this year, it came to light that oncologists in Tayside had been giving breast cancer patients a lower dose of a chemotherapy drug that is intended to prevent the spread or return of breast cancer. The clinicians have contended that that was intended to reduce the toxicity and side effects that are associated with the drug. What happens when a specialist in NHS Tayside disagrees with national guidelines? Who is held accountable in such a situation?

Grant Archibald: In a moment, I will ask Peter Stonebridge to talk about the specifics. First, I will frame what the position was in relation to breast oncology services.

Services were being provided in Tayside. A well-recognised problem with any application of anticancer drugs is their toxicity—they do harm as well as good. Sometimes, the harm can be severe. It might lead to neuropathy, in which people can lose the feeling in their hands and feet, and lose their eyelashes, some cognitive abilities and, as we know, their hair. The assessment of any consultant would be that anything that does more harm than good would be the obverse of where they want to be, so they have to make that judgment.

What you say about the situation in Tayside is entirely correct. There were discussions that led to a series of reports on NHS Tayside, and we have put in a revised model that involves consultation and explaining to patients about the standardised models, which deliver, in this case, 100mg of docetaxel, as compared with the other approach, which delivers 80 mg. That is an on-going debate that has to be undertaken between the consultant and their patient but again, you are right that we have to frame that in the context of national guidance, best practice and the evidence for what we are doing. If there is variation, it cannot be unwarranted variation.

I have taken on the responsibility of chairing the north cancer alliance, to make sure that we work in a coherent way across all the northern health boards, from NHS Tayside up to NHS Shetland. As part of that narrative, we are developing standardised dosage ratios, clinical management guidelines and advisory groups that clinicians have signed up to, to make sure that we are all doing the same thing.

Peter Stonebridge might talk more eloquently to this than I can, but within those guidelines, there is always the assessment of the patient in front of you. I might receive something different from what you might receive, Mr Briggs. That involves a judgment. Clinicians need to evidence why they arrived at their judgment and, more important, they need to evidence that they have had an informed discussion with the patient, so that they can arrive at an understanding.

Part of that is about our commitment that patients need to be involved in their care. They need to understand the risks and benefits of what we do. That needs to be an adult and informed partnership conversation.

Peter Stonebridge might want to say some more about variation among consultants.

Peter Stonebridge: Fundamentally, there is a National Institute for Health and Care Excellence guideline for breast cancer and use of chemotherapy, but it is regime-based and not dose-based. The difference was that the usual regime—not a standard regime—was being used elsewhere and, following internal audit, it was decided that the toxicity was unacceptably high. There is no national guideline on 100mg of docetaxel, although there is a national guideline around use of docetaxel.

To look at the medical background to this, if you are at odds with NICE, NICE would say that there is a guideline but not a standard. Equally clearly, the legal position would appear to be that, if you

vary from NICE guidelines, you have to get consent and document the reasons why you would vary. Oncologists consent on regime, not dosage, so any shift from what everybody else does requires consent. The oncologists at NHS Tayside have now signed up fully to the CMG for the north of Scotland and our patients are fully providing consent around what they receive.

My parallel is that, as a vascular surgeon, I can take a number of approaches to certain conditions. Some of those approaches are more extreme than others, and it depends on the patient's priorities. Every patient is an individual; it is their life—in my case—and their limb. They assess the risks and benefits of the treatment in collaboration with the clinician. Sometimes they ask for advice, and I tend to tell them that it is their life and limb and that I will not tell them what to do.

I would like to think that we are ahead of the curve on consenting in oncology in light of the events that we are talking about.

Miles Briggs: The committee often discusses the direction of travel of realistic medicine so that we can have person-centred outcomes. Do you think that that was happening in NHS Tayside by delivering the lower dosage? This is an outlier to what is going on across Scotland, and the health service has faced criticism because of it. It looks as though clinicians in the oncology department were doing something as an outlier instead of trying to implement an agenda that the chief medical officer has been pushing on health boards.

On the issue of setting a standard, whether it be for the north of Scotland or Scotland-wide, was NHS Tayside doing something for patients that it is now not going to be able to do? My key question is, what support is now being given to the Ninewells oncology team? It will be incredibly hard for the team to move forward from the criticism that it has faced. In addition, I believe that the clinical lead resigned in November. What work has been undertaken to build confidence within the team?

Grant Archibald: Perhaps I can talk about that area. Of all the issues that I have addressed in the past 11 months, that has been one of the most challenging. We have clinicians who are highly committed to their patients and dedicated to doing the best thing for them; we are applying our judgment in that regard. However, we must recognise that, when we do something different, there will be challenges to our approach. We need to look at evidence, if it is there, including competing evidence.

For me, the real challenge is this: I need to look at the patient and understand what they expect. We need to understand exactly what services we are providing and in what way. As I have said, where there is variation—whether it is warranted or unwarranted—the challenges are different.

Miles Briggs is right to highlight that, as we go forward, the issue of realistic medicine will be an even bigger area for discussion and debate. Nonetheless, a series of reports identified that Tayside was different and that we should look at that. I give the committee encouragement by highlighting that we have considered the situation and adopted the clinical management guidelines, and we are taking things forward. If new evidence emerges to support different services or treatment, that will present us with a challenge—that is an important aspect to understand.

I would like to make one point, if I might. The oncology team comprised a group of highly committed, well-intentioned and patient-focused staff working across a whole department. Importantly for the reputation of the board, we need to recognise that there are all sorts of challenges in delivering complex care, and that we are committed to doing the best that we can for patients. Where we are challenged, or where it is identified—or there is any idea—that what we are doing needs to be reviewed, we shall address that. That is our obligation, and that is what we did.

Miles Briggs: What work is the board undertaking to try to rebuild patient confidence and public trust? Has Dr David Dunlop's report been shared with all the families who have been affected?

Grant Archibald: Dr Dunlop has met a number of families and has offered to meet others. For anyone who does not know, Dr Dunlop is an expert who was formerly in charge of the Beatson west of Scotland cancer centre in Glasgow when I worked there. He came to us and reviewed a series of case notes—he thought that our consenting procedures were exemplary, and he noted that in his report.

We face the issue of trying to ensure that we support people who have already had treatment, and that we build their confidence in their on-going care and how we will engage with them while, importantly, we also consider what the situation means for everybody else who is receiving care in Tayside.

The challenge for us can be divided into two parts. First, the number of patients in the affected group was about 304. We have made it clear that, if they have, in the future, any issues or concerns with their care or their experience, or if there is progression of their disease—which some might experience, in any event—we have a record of who they are and that they have been through the process, and we will engage with them through emergency clinics to provide support. We tried to

offer further support by way of helplines and so on when the matter was first being discussed. If any of the families continue to be concerned, Peter Stonebridge and I will look at how we can engage further.

On the need to build confidence as we move forward, Ninewells hospital and NHS Tayside overall have an excellent record in all sorts of services. I will give the committee an example of how we are progressing matters—this might also relate to David Stewart's earlier question. When I came back to NHS Tayside, the board was in a particularly challenging position with regard to our performance on cancer targets. As colleagues know, there are 31 day and 62 day waiting-time guarantees; I know that the committee has discussed those with other boards. The real issue is that in any service, and in oncology in particular, the earlier the intervention and assessment, and the earlier treatment starts, the better the prognosis for the patient. I think that that is broadly understood by the population. If we went out and spoke to people in the street, they would recognise that getting early access to cancer care is a key example of where services are working well.

We therefore made a joint commitment—I am talking in particular about the three of us who are sitting at my end of the table—to improve performance in that area, because our performance at that time was at about 85 per cent. We were well off the mark and below the Scottish average. I could not accept that that was where we should be on that indicator.

11:15

In six months we achieved a major turnaround, to the extent that in the previous quarter, performance on the 62 day waiting-time guarantee increased to 96.9 per cent against the target of 95 per cent. On the 31 day guarantee, our performance was 97.6 per cent in the report for the period up to September. For the past three months, we have been reporting performance of above 95 per cent.

Why is that important? There are two reasons. First, it means that people are being seen more quickly, and they are therefore getting required interventions more quickly. That is seen as a key indicator for improvement of outcomes. It means that I am doing my job and ensuring that patients are getting access to services.

The second point is that that was the first time that we had achieved that target in four years. It was hugely important, not just for me but for the clinical body, to know that even though everybody had been working hard, it was not getting us where we needed to be. Lorna Wiggin and her team, and Peter Stonebridge and others, sat down and deconstructed the situation in a granular way. They looked at the queuing theory elements of the different parts of the journey and made a commitment to improve it. In the past six or seven months, they have done so, to the extent that we are being held up as an exemplar in Scotland, and people are visiting us from Lothian, Glasgow, Grampian and Fife health boards.

Improvement can be done, and it needs to be done. However, with regard to confidence in our cancer services, although we accept that we have been the subject of criticism, I ask you to look at the broader concept of cancer care in Tayside and to understand that the care that we now offer is better than it was six or seven months ago. We have reorganised things and made them line up better, and we are now seeing people more quickly. I acknowledge that the two colleagues who are sitting to my right can take great credit for that improvement, through the work of their teams.

On the reputation of cancer services in Tayside, I accept that there are issues around breast oncology that I will need to discuss. However, I want to amplify the fact that, in all the other cancer regimens, the improvement for patients is real—it is not just about achieving the target. That is what we are all about.

The Convener: Can you tell me in two sentences what the key to achieving that change has been?

Grant Archibald: I will give you one sentence and let Lorna Wiggin give you another, if that is okay. The key is to deconstruct the situation and understand how things line up, and to get the team to work more creatively together, rather than have everybody simply try their best.

Lorna Wiggin: We have a weekly huddle in which the members of the multidisciplinary team come together. We look at every single patient, because it is important to us that we remember that our work involves individuals and families who are going through a process. We look at their pathways, and if there is a problem or delay anywhere, there will be somebody in the room who can provide support and move the situation forward. Our approach is about the team working together as one, and it works really well.

The Convener: Perhaps the single biggest issue that was raised with the committee by the public and by health staff in our sessions yesterday evening was mental health services. Members have a number of questions on that. We will start with a question from Brian Whittle.

Brian Whittle: I will start with a straightforward question. Widespread concerns have been raised about provision of mental health services in Tayside. An independent inquiry into the

psychiatric unit at the Carseview centre was announced, and it has since been widened to cover other mental health services. The inquiry, which is being led by Dr David Strang, made one recommendation in its interim report. Why has the board, or the IJB, not accepted that recommendation?

Grant Archibald: I will frame the issue first. The challenge in our mental health services is very exacting at this time, and a key driver of our performance is availability of consultant staff. If any service could work without 14 consultants, it would do so. That is putting a real challenge to the system.

Brian Whittle is entirely right: last year the board, looking ahead, commissioned Dr Strang to examine our services and report. He did that and—as Mr Whittle said—made one recommendation, which was that we should look at the whole system rather than at the beds and the embedded services.

I will make two points about that. For us, it is not an either/or. It was not that we were not looking at the whole system; it was about how rapidly we—I am talking about myself, Peter Stonebridge, Gordon Paterson and others—could deal with the pressures in the system. We need to manage clinical risk and we need to understand what the pressures are in the system. During this year, we were 14 consultants down and we had seven services that were being run entirely by locums, which is not a situation that I would want. We had concerns about our ability to manage the bed complement as effectively and efficiently as possible.

In addition, the previous decision had been made on the basis that the accommodation at Strathmartine hospital was not what I would accept for my own relatives, so why should I expect anybody else to accept it? There were plans to remove the learning disability people from the Strathmartine facility to the Murray royal hospital, which offered far better accommodation, and to centralise in-patient adult psychiatry services on the Carseview site.

All the intentions were good. As has been said, Dr Strang said that we should look at the whole system rather than at just one part of it. My view was that we were already looking at the whole system. We have created the mental healthcare alliance, which includes councils, ourselves, the IJBs, the police, the Scottish Ambulance Service, the third sector and members of the public. It is undertaking a root-and-branch review of all mental health services in Tayside. It has met five times already and is looking at models and different ways of working, but that is going to take time.

The concern for me, Peter Stonebridge and Gordon Paterson was about whether, in the interim, we could afford not to do something regarding the in-patient bed decisions that had been made previously. Why would we not? That has been a challenge for us. We met Dr Strang as recently as last week for a further discussion. We want to make it clear that we want to work hand in hand with him in his review, which we understand will publish its final report in January. We want to support that work, but we tried to explain to him why we felt that we are facing specific pressures in relation to availability of senior medical staff who are required for in-patient services.

In order to try to deal with that situation, we brought in Mike Winter, who is reviewing the position. He is reviewing all elements of the service and has made some creative decisions, as I have described, on transferring medical budgets to nurse staffing budgets to try to ameliorate some of the risk.

There was a pressing concern regarding training provision in mental health services. NHS Education for Scotland visited us, and we were concerned that we might lose our training accreditation because of our consultant caps. Peter Stonebridge and colleagues, working closely with Mike Winter and the team in psychiatry, have successfully persuaded NES that we are on the front foot with that and are trying to improve matters. The trainees have, therefore, remained in place. Nonetheless, that was a pressure on us.

I understand why one might arrive at the view that we do not accept Dr Strang's recommendation, but that is really not the case. We tried to explain that we were embracing his recommendation and taking a whole-system view, but that we had, in the short term, a pressing need to address. The debate is on-going, but in the meantime we continue to build a bigger solution to the questions of where our mental health services are going in Tayside in the coming years, and how we will develop a more community-based model.

Brian Whittle: As I mentioned, the committee took evidence last night from the public and from clinicians. I said that I would pass on some of those views and allow you to respond. As you described, there is a shortage of psychiatrists in the Dundee area. The public are saying that the situation is leading to a lack of continuity of care, because there are far too many locums. The public feel that you are not listening to or consulting them, and that they cannot access staff and are being held at arm's length.

We then brought in the healthcare professionals. As Grant Archibald said, 14 posts out of 35 are currently vacant. That is a vacancy rate of 40 per cent, which is much higher than the rates across the rest of Scotland. The healthcare

professionals feel that there has been a complete lack of consultation of the psychiatry unit on the way forward. More worryingly, they feel that there would be repercussions against them if they were to raise any issues. The word "bullying" was used, and it is felt that there is a lack of clinical leadership.

If we put all that evidence together, it paints a very worrying picture for the committee, especially on the back of the specific circumstances in Dundee. We understand that Dundee has a very high suicide rate and high rates of problems around drug and alcohol dependency. NHS Tayside is rated very poorly against the 18-week treatment target. To me, that all suggests a system that is in crisis. What do you feel about that? What is your plan for moving forward?

Grant Archibald: I will take those questions in turn; if I miss one, Mr Whittle will remind me.

With regard to design of services and involvement of staff, we work in partnership, as I have said previously. The matter has been discussed in our area partnership forum, and we have partnership arrangements in our mental health services, as well. I am therefore disappointed that people feel that they are not being consulted and involved.

On the clinical leadership model, we have said that we are a clinically led, management-enabled body, which is working very well in acute services. The challenge that we face in psychiatry—I call it an aggregate of challenges over many years, rather than a recent arrival—is that we have lost clinical leaders in that service. Peter Stonebridge, in encouraging people to step forward and become clinical leads, has found people working in psychiatry to be less responsive to those efforts than the staff who work in acute services.

My view is that architects should live in their own houses. If people want to be part of the design, that obliges them at times to step forward—there is reciprocity. If people want us to listen, we need them to step forward and stand with us to have that debate. We therefore need to work harder to enable the psychiatrists to do that. Again, I highlight that we brought in Mike Winter to build greater confidence that we are trying to do something that is different from what has been done previously in Tayside.

In response to what was said about public involvement and consultation, I am, again, disappointed. Tayside has previously had a good reputation for its engagement with the public. We have public representatives and third sector groups involved in the mental health alliance. Given the work that is happening, there is either a disconnect in how we are communicating that work or there is a genuine issue with representation. Whichever is the case, we will take that issue away from the meeting—as the committee would expect us to—and address it. That is not a rebuttal: we embrace the criticisms that have been made of us, and we will go away and review matters to see whether we are doing all that we can in that regard.

On the future direction of the service and how we engage with that question, I have said already in this meeting—and in every meeting that I have with staff and with the area partnership board, which I co-chair—that we are committed to working with the staff. It is absolutely not in my interests to have an environment in which staff feel that they are undervalued.

Brian Whittle used the word "bullying", which I really hoped would not come up today. Since the Sturrock review, we have always been committed to ensuring that we work fairly with our staff wherever we can. If there is evidence of bullying, I say now, in this public forum, that people can write directly to me and I will address their concerns. That is not the environment that we work in, and that is not the way that we work together.

We are currently dealing with five on-going cases of whistleblowing in relation to a range of subjects. We are appointing a lead for whistleblowing at non-executive board level. We take all such matters very seriously, so I am very disappointed to have heard the specific word "bullying". Nonetheless, I will learn from what has been said, and I will go away and speak to my staff-side colleagues and some of the people to whom the committee has spoken, in order to find out why such behaviour is being mentioned.

Everyone at this table, and everybody who works in senior management, senior clinical roles, and non-executive and executive roles in the board, is absolutely committed to the view that our staff are our most valuable resource. We work with staff and support them, and we give them credit for what they do, through the good times and the bad times.

Brian Whittle: Thank you for that. Would you accept that, if staff feel that they are going to be persecuted for stepping forward, it is very unlikely that you will get any collaboration from them?

Grant Archibald: We recently received the results of our iMatter survey. The issue is that, in the previous year, we did not get a suitable response that enabled us to read anything into the report, because the response rate was below 60 per cent. The rate is now at 61 per cent—we have only just gone past the previous figure, but that allows me to review what the staff think of the organisation. It is not really important what I think; it is about what the staff think and what their lived experience is.

There should be nobody working in NHS Tayside who thinks that they cannot come forward and speak either to me, the chair or anyone else in a senior position. If that is the case, we will pursue it. Our culture is to embrace our staff and to work as a team—as we have just described in respect of cancer care—that seeks to empower people and make them feel rewarded for what they do. That has been my narrative throughout this meeting because it is my lived experience and it is our style.

11:30

Miles Briggs: I will follow on from what Brian Whittle said. Two key challenges around mental health were outlined to us. The first is about people who are in crisis in all three IJB communities, and then, beyond that, the stepping down of facilities before people can return home.

Across Scotland, the ability to introduce new facilities and create new bed spaces is important for health boards. It seems to be crazy that the Mulberry unit at Stracathro has been closed. Do you plan to reopen that? It is quite clear that that capacity is needed; the unit could be reopened. We have discussed the staffing challenge, which is key, but what is the board doing on stepping down care facilities and returning the service to the community?

Grant Archibald: I will go back to David Strang's report. We are trying to do it all in the round. The key question is whether it makes sense to make use of facilities or to redesign services. Designing and having facilities without staff is no use to me, and I will not run unsafe staffing levels. As Ms Harper will know, managing a ward is difficult and requires adequate staff.

The challenge for us is that there has been disaffection around mental health services in NHS Tayside for some time. There have been reports about suicide rates and people in crisis, which is why the board commissioned David Strang.

I have also commissioned the Royal College of Physicians of Edinburgh to report to me and the board before Christmas on governance of mental health services in Tayside. I moved on that before Dr Strang reported because we see it as a challenge.

I need to describe to the committee how complex the issue is. If it was immediately resolvable, we would do that. I will give you one view. The rate of admission of Dundee residents to the Carseview centre is 50 per cent higher than the rate from the rest of Tayside. I find that interesting in the sense that, even with the crises that exist in Dundee, there should not be so marked a variation. That suggests to me that the problem is with the design of the services. Rather than opening more beds to deal with that problem, we should be providing anticipatory care. What are we doing to anticipate those who are going into crisis? How early can we intervene? What can we do differently?

To come full circle and go back to social prescribing, I note that I was with the minister at the botanic gardens in Dundee about six months ago to talk about a form of social prescribing. There are lots of green spaces in Dundee and there was a scheme to encourage people to get into organised groups and walk through parks. One person who talked articulately had been in social crisis, felt dislocated from society and was parasuicidal. He talked about how he joined the walking group and it gave him a sense of wellbeing and, more important, it gave him a series of familial and friend connections that he did not have access to previously. He was training to be a park ranger. That is a better story than giving somebody drugs or admitting them to a ward.

Miles Briggs: I fully respect that, but we are in the here and now of needing crisis beds. Look at where the Mulberry unit is located. What discussions have been had with NHS Grampian, for example, on a cross-border sustainability plan to reopen the unit? That is the question that I want answered. This is a chance to provide a state-of-the-art facility and meet a need that exists today.

I completely accept that we want to see that preventative health model, but Tayside and other parts of Scotland are in a difficult situation with people who are in crisis needing support today.

Grant Archibald: I understand that, but I am looking to have colleagues such as Mike Winter and others assess our estate and decide whether we should provide a service just because a facility exists. What is the best model?

We have commissioned Mike Winter to come in and work with Gordon Paterson and colleagues, including our mental health colleagues, and if they arrive at a solution, that is clearly the solution that we will consider. At the moment, however, I am awaiting a proper assessment of what we can do next and what it is best to do next.

I hear what you are saying about the Mulberry unit. I speak to the chief executive of NHS Grampian every week on a Tuesday morning, so I can have that conversation with her, but at the moment I am waiting to assess what we can do with the existing workforce—not necessarily just with the real estate.

The Convener: I will take you back to David Strang's report and recommendation. My understanding is that he wanted you to stop centralisation of services until he was able to provide a wider recommendation. As you said, that is due in January. Would it have been wiser to wait

for that? In other words, are you in danger of pursuing a course of closures or changes that were already under way, having been warned, "Wait a minute. Don't do any more until you have thought about the whole picture"?

You say that you are pursuing those measures at the same time. Is there a risk that you will come to the end of the strategic review, conclude that you should still have some of the facilities that you have just closed or removed, and wish that you had listened to David Strang in the first place?

Grant Archibald: I assure you that we are listening to and engaging with David Strang—we did so as recently as last week. For me, the key issue is timing: timing is rarely perfect. We face a series of issues: as Mr Whittle said, there is a 40 per cent vacancy rate in consultant psychiatrists, and I cannot say that I will fill those vacancies any time soon. We have tried internationally to fill psychiatrist jobs, with special dispensation from the Government, but we cannot recruit to that level. That is my reality. I am therefore required to cut my cloth accordingly, to an extent. Part of the idea with centralisation was to improve accommodation, and part of it was a reaction to the realpolitik of where we are right now.

It was never said that the arrangement was once and for all. We have had a debate on that with David Strang, too. We were seeking to have the freedom to act, even with his recommendation in place, on the basis of the pressures on medical staffing. Had our training accreditation been removed, that would have removed 36 junior doctors from the system. That is what we have been dealing with. It is a Gordian-knot type of problem. I am willing to listen to all advice, but there will be a time when people including me, Gordon Paterson and others will have to execute our roles as responsible officers, making recommendations either to Government or to our board, saying, "We hear all that, but this is where we are."

As we sit here today, we are still engaging positively with Dr Strang. You are right: we await the report in January to see what else it says about services, and we continue to manage a system that we would not design in the same way were we to start again.

The Convener: I see that Gordon Paterson wishes to come in, but I will just say that, on this area, one of the concerns that we have heard, which particularly impacts on staff morale, is that some of the ward closures, for example at Kingsway and Craigowl, have happened overnight, and the staff feel that they had no advance warning of the changes. That might well feed demoralisation or the desire among some of the key people whom you have mentioned to find jobs elsewhere.

Gordon Paterson: I want to reiterate what Grant Archibald has said. Perth and Kinross IJB hosts in-patient mental health services. In January 2018, following extensive consultation the preceding year, which involved a range of options being considered and consultation and engagement taking place, including with the NHS board, the three IJBs, the area partnership forum and the clinical quality forum, Perth and Kinross IJB took the decision to approve the preferred option, which was to consolidate mental health services in Dundee, to develop a centre of excellence there and to consolidate learning disability services in Perth and Kinross.

That decision was taken in January 2018, but Mr Strang recommended that we should pause the service redesign. Perth and Kinross IJB carried out a review and risk assessment and, having taken full account of David Strang's recommendation, we determined on 27 September that we should, in fact, continue with the redesign.

David Strang's recommendation highlighted the need for us to develop end-to-end pathways of care. However, as Grant Archibald said, the IJB took the view that the redesign did not require to be suspended while those pathways were being developed, so we could proceed with the redesign. That involved driving forward significant environmental improvements, addressing concerns about fire safety, removing ligature anchor points and creating patient-centred environments, and we felt that proceeding on that basis would provide a better environment for the small number of people who will always need hospital beds.

Doing that has not necessarily locked us into that being the model moving forward, because parallel to that, extensive work is now under way with the Tayside mental health alliance. It involves the three health and social care partnerships, NHS Tayside, public health, primary care, the staff side, chief social work officers and advocacy groups. They are working on pathways and developing a new approach that will seek to join up the three strategies that the health and social care partnerships have developed around community mental health. Those are about how we keep people well, how we respond to them in their own homes and how we marshal the resource of third sector organisations to ensure that they are getting alongside people and providing the necessary support.

The mental health alliance is doing that work, looking at five workstreams around workforce, crisis care—I am sorry that Mr Briggs has gone—learning disability, rehabilitation pathways and emotionally unstable personality disorders. We felt that we did not need to suspend significant

environmental improvements and opportunities for people to have better and safer care while we were developing a strategy. Those two things could be done in tandem and that is essentially where we are now.

The Convener: Do you recognise the point about staff feeling that they had no notice of some of the changes that were made to their working environment?

Gordon Paterson: I recognise that staff have told the committee that that is a concern. I absolutely recognise that when we are doing the redesign we will have to be sensitive to the fact that, if we are asking staff to transition or be redeployed, we need to take time and have meetings and engage with the staff side. The progress that we have made since the IJB made the decision in January last year has been slow because we have not wanted to rush things through.

We have been engaging with the staff side about redeployment and transition, and the cost and impact that they would have on staff. On the two examples that you cited we felt that there had been a level of engagement, so perhaps we have to reflect on how effectively we did that. However, in relation to Craigowl, we had 60 nursing shifts that could not be filled the next week so a decision had to be taken rather urgently in order to provide safe patient care.

The Convener: On the bigger picture of mental health, you said that you will await David Strang's full report with interest and that you are carrying forward a review in parallel with the changes that are being taken forward. Who will take the lead and make the critical decisions on mental health strategy after receipt of David Strang's full report? Where will that responsibility lie?

Grant Archibald: That is a joint responsibility: we will have to work in tandem. Although there are hosted services, Peter Stonebridge, who is the senior medical officer of NHS Tayside, and I, as the accountable officer, have a responsibility to the patients. That is not a confused landscape, for me; it is about working collaboratively or collegiately with my IJB, which was the whole intention of hosting arrangements. The responsibility for patients never leaves me or Peter, while hosting and design of services is a key area that has been delegated to the IJB. If we are at a different place, that would be incredibly disappointing, because we work so closely together.

The Convener: Let us move on to primary care.

David Stewart: How well does the new GP contract work in NHS Tayside?

Grant Archibald: I ask Peter Stonebridge to answer that question—he will do so better than I could.

Peter Stonebridge: The new GP contract is a primary care contract. It is about reorganising primary care around a more integrated approach involving other workers.

Progress on it is slow, and some people have asked for an interim report on it. The problems include premises, so we are taking over and building places in Errol. Obviously, we have had issues with the Bridge of Earn practice and its accommodation. There is also the issue of information technology provision. A number of initiatives are being taken forward and have timetables attached to them, but most of the IT is relatively old and needs to be replaced.

11:45

David Stewart: Peter Stonebridge has touched on some of my questions. I am particularly interested in rural areas. The committee has taken a lot of evidence from various organisations about provision in rural areas. As you will know, the Royal College of General Practitioners had some questions about the contract, particularly around rural provision. Peter Stonebridge mentioned the Bridge of Earn practice. I understand that 3,000 patients had to be "redistributed" to various practices, including in Perth, which was a major disruption. How well does the contract serve rural GPs?

Peter Stonebridge: The general practice in Bridge of Earn was a private, or independent, provider. We currently have a mixed economy in that we have four 2C practices, which the health board runs, while the other—I think—59 are partner practices. We co-ordinate how the two work together through our primary care medical services and our associate medical director in primary care, Dr Jane Bruce. Despite the issues, that seems to have gone relatively well in terms of safeguarding patient safety and patient access to primary care services.

Further planning is needed, particularly in provision of care in Perth and Kinross, and standard operating procedures are being developed for similar events. We had a similar experience in Dundee, but it was somewhat easier to deal with because we had an existing 2C practice and there was significant cross-cover.

Recruitment is very difficult in rural areas, and at least one practice is vulnerable to that. However, in those circumstances, the good relationships between the health board practices and the surrounding partner practices means that cover is provided.

David Stewart: Do you have a list of GP practices that you consider to be high risk? Clearly, this is about prevention and damage limitation in the long term. We have heard that 3,000 patients had to be redistributed. Approximately how many GP practices in the Tayside health board area are at risk of closing down?

Grant Archibald: The Bridge of Earn practice had a series of almost unique complexities around it, which led to a difficult and reasonably late decision—for which we have apologised—that saw the patients being distributed rather than some other model being adopted. The reason was that it was considered to be in the best interests of the patients. Although it caused inconvenience, there were issues about the unwillingness or unavailability of other people to take the practice over. The fact is that, for many years, the practice had had difficulty recruiting GPs.

We have committed to working with Gordon Paterson and colleagues to provide key care services—particularly nursing services—in Bridge of Earn. At the moment, we are redeveloping a property in the village that the board owns.

In addition, we met Karen Reid from Perth and Kinross Council and Gordon Paterson to discuss the change in the demography of morbidity—both planned and unplanned—in Perth. I understand that 7,500 new houses are to be built in the Perth area in the next few years, which will materially change the profile of certain areas, and we have agreed that we will be involved as one of the key services. That means that, in addition to schools, GP practices will be part of the debate.

We are doing all of that, and we are conducting a review of the events that compressed into the Bridge of Earn practice, so that we learn from that experience.

Off the back of that, I immediately asked Dr Jane Bruce, from our primary care division, to start to review practices elsewhere across Tayside—particularly in rural Tayside—that might be vulnerable. Those that might be vulnerable are single-handed practices, when an elderly GP seeks to retire, and practices that are in properties that are unsuitable for the provision of a range of services.

To address that situation, we have also called on the support of Sir Lewis Ritchie. He and I have agreed terms of reference for him to engage with me and give us advice on hubs. He will visit Bridge of Earn and other rural parts of Tayside. Our challenge is that we may need to look at GP practices coming together or having satellite services. We need to reinvigorate those. Part of the debate that we are having with Karen Reid relates to the co-location of services and what might be put on the Perth royal site that could create a hub around social work as well as around GP services. We are also thinking about what we can do at Pitlochry and Auchterarder.

We have a list. I do not have that list or the numbers to hand, but we have already commissioned that review to create red, amber or green—RAG—ratings for the practices that are most at risk. We do not want to find ourselves serially in circumstances like those in Bridge of Earn. Those circumstances were unique, and we have apologised to the populace for what happened. We have committed to looking again at what services can be provided pro tem and then having a bigger debate as the population changes. I think that it is planned that 750 houses are to be built around Bridge of Earn. If that is the case, we will have to consider a different set up, and that is where Sir Lewis Ritchie's ideas will help us.

David Stewart: I did not really expect you to have figures to hand, but could you write to the committee with the number of GP practices in Tayside that are at risk and the number of patients who would be affected? That would be useful information for the committee to have in the long term.

Another point that the medical director raised is the issue of boards taking over GP premises. I have talked about that with people in NHS Highland, and I have met many GPs to discuss it. There are many pros and cons, but it can be a positive development.

My first question touched on finance, and I want to raise that issue directly with you. If, in the long term, you are taking over the premises of every GP practice in Tayside, that will be an immense financial undertaking. Have you had any assurances from the Government that it will give you direct support to enable you to buy new GP premises or take over GP premises within your timescale? It is certainly a commitment in the contracts, is it not?

Grant Archibald: That is a work in progress. I have commissioned a site review of all the properties. As I said at the start of this evidence session, we are the third-biggest property owner of all the boards in Scotland. That is a challenge, because we have quite a large maintenance backlog. The questions are: why put money into properties if we could get out of them and where is the potential for joint property relationships with the council? Brechin high school was deliberately built with an extra wing that allows drop-in centres for men's clubs and so on. That is putting the school at the heart of the community, and that is the kind of flexibility that we need.

We are assessing all our properties. In addition, there is the schedule for the GP practices, which

are on a spectrum from those that will need quite a bit of refurbishment to those that are relatively newly built or well maintained. We need to design the models and then think about the properties—form would follow function. I am not a great believer in building something and then using it; let us design the model and then see what can be built based on it.

I know that I am calling very heavily on Sir Lewis Ritchie, but he had such invigorating ideas about creative hubs that I am keen for us to engage with his ideas about supporting communities and GP practices playing a bigger role as well as looking at examples from elsewhere.

David Stewart: In Tayside, as in the rest of Scotland, many GP practices will need to combine with other GPs and new premises to allow allied health professionals to carry out their excellent work, although perhaps not on site. I know that you do not have categoric answers from the Government yet, but it seems to be a huge financial commitment. I do not know whether Stuart Lyall can answer this question, but is that something that NHS Tayside has on a risk register? Providing premises for GPs across a very large region is a massive financial commitment. Are there not huge red flags about that, given that the region has had more than £80 million in brokerage?

I am sorry to have thrown you a very difficult question at the end of the meeting, but it is a crucial issue.

Stuart Lyall: Yes, it is a crucial issue, and we have set up a local primary care premises group to look at it. We are modelling the costs that the board might inherit and comparing them with the funding that might be available. I cannot answer categorically whether the funding will cover the costs, because that information is not available.

David Stewart: Just out of interest, do you have a financial risk register as part of your operation as the director of finance?

Stuart Lyall: Yes.

David Stewart: Is that issue on the financial risk register, and is it high up?

Stuart Lyall: Yes—it is high up the risk register. Property overall is high up our risk register, because we have several properties that we need to look at. We have a large backlog of maintenance and, to be blunt, we have too many properties. There is a whole infrastructure around investing in our property framework.

David Stewart: I will not open another line of questioning, because we are tight for time, but you will know about the work that we have done on the Queen Elizabeth university hospital in relation to water bacterial infection. Clearly, having a very large site raises issues about hygiene, infection and risk for vulnerable patients.

Thank you for your answers. It is useful to know that the issue is high up the risk register. It is an issue that we will raise with other boards. Providing GP premises is a good idea, but I am concerned about how it will be financed, particularly in boards that have had serious financial worries over the past few years.

Emma Harper: We should be covering some good news stories, too. NHS Tayside participates in the Scottish graduate entry medicine programme. That is one way in which we can get rural GPs and grow our own graduates in medical practice. I am also interested in the better health and better care aspects that are mentioned in our briefing. Pages 237 and 239 of the briefing's 326 pages talk about the good work that is being done to implement the better health and better care programmes, for which the staff should be commended.

Grant Archibald said that NHS Tayside would be willing to learn from other boards, but I am sure that they could learn from you as well. I am looking at what is being done on alcohol, brief interventions, child healthy weights, dental care, smoking cessation and other issues including addressing deteriorating patients in acute care as well as in the community. It would be good to hear some good news stories, too.

Grant Archibald: Thank you for the question. We started off by saying that we are the product of our staff: we are a staff-based service, and it is the individual efforts of 14,000 NHS people and all those in social work and so on who work in partnership with us, that dictate whether we are successful. That is why I was keen to understand concerns that Mr Whittle had heard from the staff. Our commitment is that we work best as a team.

I am immensely proud of many things in NHS Tayside. Lorna Wiggin might be embarrassed to report this, but this week we achieved 98 per cent for our unscheduled care performance. It is some considerable time since a major health board in Scotland achieved that target. I heard the cabinet secretary say that we are 10 or 15 points better than England. We are doing well, in that respect.

We have talked about cancer services, and we have developed an exemplary relationship with the medical and nursing schools in Dundee. We have regular engagement with them. Part of our plea to them is about how we get someone who trains or works in Dundee to stay and work for NHS Tayside. That is about making ourselves an attractive proposition.

Recently, we were at the *Daily Record* staff awards, where our liver treatment unit and analysis team won another national award—they

are running out of shelf space for all the awards that they have won. It is important to celebrate success.

When something goes wrong in the health service, it is important because it is a tragedy for an individual family and for others. We must understand that we are in a service delivery model that has to recognise the huge implications when things do not go right; therefore, it is right that we concentrate on those events and learn from them when they happen. By the same token, however, every day in all our hospitals, services, GP practices and beyond, people are working incredibly hard and delivering excellent services.

In some of the key areas that Emma Harper mentioned, we are doing very well indeed, and we need to build on that. I am particularly impressed by the efforts that we are making in relation to child health and healthy weights, as well as in smoking cessation. Much of what we have talked about today relates to the public health environment: NHS Tayside wants to become a health service, not an ill-health service. We want to promote health in any way that we can. We want to anticipate when people are getting into psychological despair or disorder, or into drug use, and we want to support them. We want anticipatory care models for those things just as we have them for chronic obstructive pulmonary disease.

We need to get out there and play our role. We are the biggest employer in Tayside; there cannot be many people in Tayside who do not have a relative who works for the health service. The chair and I want our staff to feel proud of, as well as rewarded and recognised for, what they do. My aim is for them to see the product of their efforts and to be listened to.

12:00

The Convener: That is excellent. I thank all the witnesses for their evidence this morning. We are grateful to all those who attended and supported our private meetings, as well as to those who have attended today's meeting. As I indicated earlier, we will be in touch with NHS Tayside and the IJBs shortly in relation to the points on which you have offered additional information or on which we seek further information.

Meeting closed at 12:00.

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