OFFICIAL REPORT
AITHISG OIFIGEIL

Public Audit and Post-legislative Scrutiny Committee

Thursday 8 October 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 8 October 2020

CONTENTS

PUBLIC AUDIT AND POST-LEGISLATIVE SCRUTINY COMMITTEE
22nd Meeting 2020, Session 5

CONVENER

Jenny Marra (North East Scotland) (Lab)
*Anas Sarwar (Glasgow) (Lab) (Acting Convener)

DEPUTY CONVENER

*Graham Simpson (Central Scotland) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Neil Bibby (West Scotland) (Lab)
*Bill Bowman (North East Scotland) (Con)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Alex Neil (Airdrie and Shotts) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

John Connaghan (NHS Scotland)
Pam Dudek (NHS Highland)
Richard McCallum (Scottish Government)
Edward Mountain (Highlands and Islands) (Con)
Professor Boyd Robertson (NHS Highland)

CLERK TO THE COMMITTEE

Lucy Scharbert

LOCATION

The Mary Fairfax Somerville Room (CR2)

Scottish Parliament

Public Audit and Post-legislative Scrutiny Committee

Thursday 8 October 2020

[The Acting Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Acting Convener (Anas Sarwar): Good morning, and welcome to the 22nd meeting of the Public Audit and Post-legislative Scrutiny Committee in 2020. I welcome Edward Mountain, who is attending for agenda item 2.

Before we begin, I remind members, witnesses and staff that social distancing measures are in place in committee rooms and across the Holyrood campus. I ask everyone to take care in observing those measures over the course of this morning's business, including when exiting and entering the committee room. I remind members not to touch the microphones or consoles during the meeting.

Agenda item 1 is a decision on taking business in private. Does any member object to our taking item 3 in private? Any members joining us remotely who object should raise their hand.

As there are no objections, that is agreed.

Section 22 Report

"The 2018/19 audit of NHS Highland"

09:30

The Acting Convener: Agenda item 2 is on a section 22 report, "The 2018/19 audit of NHS Highland". I welcome our witnesses, who are all participating remotely: Pam Dudek, chief executive of NHS Highland, and Professor Boyd Robertson, the board's chair; John Connaghan, chief executive of NHS Scotland; and Richard McCallum, the Scottish Government's interim director of health finance and governance. I invite Professor Robertson to make an opening statement.

Professor Boyd Robertson (NHS Highland): Madainn mhath—good morning. I thank the committee for the invitation to attend to discuss the NHS Highland 2018-19 annual accounts and the section 22 report. My role, as interim chair of the board, started on 1 March 2019, and Pam Dudek took up her post as chief executive officer only at the beginning of this week. Our knowledge of the period in question is therefore somewhat limited. However, I am sure that we can provide the committee with an assurance that the—[*Inaudible*.]—and that significant improvements have already been made.

I acknowledge the extraordinary efforts of our health and care team, our managers, our patients and our council colleagues for the way in which they have handled the response to the Covid-19 pandemic. Although we are still very much in the throes of the crisis, the response from our teams has been remarkable. I place on record my sincere thanks and admiration for that.

Since my appointment last year, the organisation has made notable progress in addressing two of the major challenges that confronted us during 2019-20. The first was the Sturrock report, which was published in May 2019. That was a troubling and defining moment for NHS Highland. The report highlighted long-standing issues of bullying and harassment, which had a significant impact on current and former employees. The report's findings were sobering for the board and for our staff. They were also alarming for our patients and communities.

Many positive actions have been taken to improve the culture of the organisation over the past year, including the establishment of a culture programme board, the appointment of an independent external adviser, staff engagement and staff training events, and the establishment of new employee services. One of the most significant initiatives has been the new Healing

Process service, which was co-produced by whistleblowers, the staff side and our human resources team.

The second major challenge that we faced concerned our financial performance, which, in 2018, led to NHS Highland being escalated to level 4 of the Scottish Government's performance escalation framework, partly as a result of a significant accumulated financial deficit, which resulted in the need for financial—[*Inaudible*.]—the Scottish Government.

Significant progress has been made in tackling that deficit. A programme management office has been embedded to direct and drive cost improvements opportunities, and a number of revised financial governance arrangements have been put into place. By the end of the financial year 2019-20, we had fully achieved our substantial savings target, with a significant amount being made on a recurrent basis. At the year end, outturn exceeded our financial plan—[*Inaudible*.]—requirement was lower than the approved target. That has been a tremendous achievement and is the result of a huge amount of hard work by our clinical and management teams and by our programme management office, which was initially supported by external consultants.

There is much more to do in order to achieve financial balance. That has, of course, been affected by the impact of the pandemic. Much of our progress is outlined in the 2019-20 external audit report, which will be published in due course.

Pam Dudek and I will be happy to answer the committee's questions.

The Acting Convener: Thank you, Professor Robertson.

I invite John Connaghan, the chief executive of NHS Scotland, to make an opening statement.

John Connaghan (NHS Scotland): Thank you. I will be brief, in the interests of maximising the time that is available for questions.

I echo Boyd Robertson's thanks to the health and social care staff in NHS Highland for the work that they are doing.

I will make four brief points. First, we see signs of progress financially and in performance, but there is much more still to do. Secondly, I am delighted to see the emergence of a very strong team in NHS Highland, which was achieved through open competition. Thirdly, I acknowledge that progress has been made in establishing a sound base of new policies and a demonstrable set of practical actions to tackle culture and engagement issues. Finally, I note that the Scottish Government has been, and will continue to be, supportive of NHS Highland in supplying external and SG advice on finance, clinical services, human resources and transformational support.

The Acting Convener: Thank you, Mr Connaghan.

Before we talk in more detail about the Audit Scotland report, I want to ask a more topical question about the Covid response and get any reflections from NHS Highland from a leadership and governance perspective. I want to give Professor Robertson, Pam Dudek and Mr Connaghan an opportunity to reflect on the long queues of people waiting to get their flu jabs at a time when we are trying to support social distancing measures. I am not sure that asking mainly elderly and infirm people to wait in long queues on a cold Highland morning was very helpful in reducing the spread of the virus. Do the witnesses have any reflections on the wider Covid response or the fact that people had to queue down the street at 9.30 in the morning in order to access their flu jabs?

John Connaghan: We of course very much regret anyone being inconvenienced when accessing their flu jab, but I will say a word or two about the wider Covid response. The committee might want to know that our response is the subject of extensive planning and is guided as much by the science as by the clinical imperatives.

Members might be aware that, earlier this year, we published "Re-mobilise, Recover, Re-design: The Framework for NHS Scotland", which still holds true. As part of that remobilisation, we need to deliver a number of objectives, which cover not only patient safety but our ability to handle the Covid response while maintaining critical services. The framework is on the Scottish Government website.

Before I hand over to colleagues in NHS Highland for more detailed comments, I note that the Scottish Government has commissioned and received a detailed remobilisation plan from every health board in Scotland. Those plans are under consideration and take us to the end of this financial year in relation to the provision of services.

The Acting Convener: Before you hand over to colleagues, I note that you did not really reference the issue about the flu jabs, apart from in passing. On Twitter, the Cabinet Secretary for Health and Sport robustly criticised NHS Highland and said that she was in contact with it on the issue. Do you want to say a bit more about that contact?

John Connaghan: I am aware of the circumstances in Invergordon—we were made aware of that situation, and it is regrettable that people had to queue. NHS Highland has examined its booking and communication practices. We have 2.25 million people in Scotland

who receive a flu vaccination, so we will never get it right all the time, but we need to get it right most of the time. We need to learn from such issues and ensure that the learning is rolled out around Scotland.

The Acting Convener: Was that issue with the flu jab isolated to one location in NHS Highland, or is it part of a wider problem that is replicated in other parts of Scotland?

John Connaghan: We will always have issues of that nature at the start of such massive programmes. One thing that we need to do is look at the way in which the national public message about how people access flu jabs is put out. You will be aware that we have a delivery sequence that delivers the flu jab first to those who are most in need of it—the over-65s and the vulnerable—before moving on to the other cohorts. The sequencing of the messaging will be important over the course of the next two months as we move through the delivery of the flu jab to different cohorts. As I said, we need to learn from that.

The Acting Convener: Are you saying that the messaging was not quite right this time, but that we will get it right in the future?

John Connaghan: I would like to hear from Pam Dudek about the messages that were local to Highland. She will have a little bit more on that—

The Acting Convener: What about the Scotland-wide messaging? Before I go over to Pam Dudek, are you saying that you are hopeful that we will get the messaging better in the future, as we did not get it right for this cohort?

John Connaghan: I am hopeful that we will get the messaging right and that it will be appropriate. As I said, we will take lessons from any part of Scotland where we did not get it quite right. There was clearly an issue in Highland, and that will be part of our thinking as we consider how to deliver such messages around Scotland.

Pam Dudek (NHS Highland): I apologise profusely for the experience that people had at the weekend. I was on call at the time and I put out a message on Twitter to apologise.

To be fair to the practices that are working with our public health department to set up this significant programme, they thought that they had all their plans in place. To prevent queues, they had sent out a robust letter to individuals, which was clear about the process and the appointment system.

We were naive in our consideration of wider welfare issues, as you said and as people stated on Twitter, and about the fact that, in a rural setting, it is not always possible for people to turn up neatly at specific times for appointments. There is learning from that, which was not so much about the technical delivery of—

The Acting Convener: Was it an isolated incident, or did similar things happen in other parts of NHS Highland?

Pam Dudek: I have a review coming to me today that will tell me about the situation across NHS Highland. That is the one situation that has been reported to me; I have not had any further reports. As people implement the programme, there will be further learning.

Our head of primary care is on the case and is doing a review, as I said. I have asked them to consider the wider welfare aspects—including the weather and rural travel, which should be natural for us to think about—and actions that we can take to support people who cannot turn up exactly on time, perhaps because they do not come in a car and come by public transport. I will have an update on that today.

There is a range of support for our general practitioner practices that are delivering the programme at weekends after working all week. As you have acknowledged, it is a big programme for our staff and population, and we need to keep it under close surveillance.

The Acting Convener: If you could share that review with all locally elected members, I am sure that they would greatly appreciate it—I can see one such member nodding. Sharing the review would help to build confidence in the programme.

Pam Dudek: We will prepare a briefing for members.

The Acting Convener: As a follow-up to that, I understand that there were issues with an outbreak at Belford hospital. Can you say a bit more about the cause of that outbreak? Was it linked in any way to not having routine testing of staff?

09:45

Pam Dudek: No, we do not have an outbreak at Belford hospital, but a member of staff has tested positive. There is an increased prevalence of Covid, much in line with what we are seeing right across Highland, and we have small clusters in the community.

The Acting Convener: Can you tell us how many procedures have been cancelled or delayed as a result of Covid? What assessment, if any, has been carried out to look at the long-term health impacts in NHS Highland as a result of procedures being cancelled?

Pam Dudek: I cannot give the exact cumulative number at this point as I do not have it in front of me, but I could get it for you.

We are monitoring weekly any cancellations for surgery, and individual reports come to the management team on a weekly basis. We have also taken further action on remobilisation in that area, as we seek to understand some of the nuances relating to the cancellations and try to ensure that they are minimised. We have strong surveillance on that, but I do not have the cumulative number in front of me.

The Acting Convener: I am concerned about two areas in particular. One is cancer treatment, and the other relates to procedures more widely and the long-term comorbidities that cancellation may cause. The latest available figures in the Audit Scotland performance report are from March 2019. The figure for

"treatment within 62 days of urgent referral"

was 75 per cent, when the standard was 95 per cent and the average for Scotland was 81 per cent. I imagine that the figure has dropped drastically during the Covid period.

For the treatment time guarantee, NHS Highland's performance in March 2019 was 54 per cent, when the standard was 100 per cent and the average for Scotland was 68 per cent. Again, I imagine that the figure has fallen drastically as a result of Covid-19.

Do you have any reflections on that, and on the long-term impact on NHS Highland?

Pam Dudek: John Connaghan might want to come in and support me in answering that question.

The 62-day cancer target figure is now sitting at 69 per cent, and we are working very hard to rectify that. We understand the areas in which that applies, such as urology, and the actions that need to be taken, and we are on a trajectory of improvement. We are taking a clinical prioritisation approach to deal with urgent cases and work our way through any backlog. We are also dealing with some historical issues, as well as having moved through Covid. With regard to the 31-day target, we are now consistently at 100 per cent as of September, so we are in the right position in relation to the standard.

Overall, to compare our recovery performance with our pre-Covid performance measures, our March 2020 measure for the TTG was 58.2 per cent, whereas we were previously at 54 per cent. We are on a trajectory that we set ourselves to recover to our pre-Covid performance, in the knowledge that some aspects need a lot of work because they were not completely where they should have been at that time.

The Acting Convener: Do you accept that, although your trajectory is returning to pre-Covid levels, those levels were unacceptable?

Pam Dudek: Yes, absolutely. We are working hard on all the standards, and the 62-day target in particular, through weekly surveillance and through our performance recovery board, which is looking at improvement and redesign.

The Acting Convener: Mr Connaghan, do you have any reflections on the number of procedures that have been cancelled and the performance of NHS services more widely? Has any analysis been done of the long-term health impacts in Scotland as a result of cancellations?

John Connaghan: There is quite a bit of research on the Covid implications. The results are emerging, so I cannot say much about that now, but we know that there are long-term implications for some patients in respect of respiratory functions and possibly neurological conditions.

At the heart of your question, however, is what is happening to the patients who are waiting on lists, what the build-up is and what the impact is on those patients. I will give you some more detail on the Highland area.

As part of the Government's "Healthcare waiting times: improvement plan", we saw immediately, pre-Covid, a significant improvement in out-patient performance for NHS Highland. That was impressive, because the board also managed to keep a lid on the in-patient TTG performance while coping with all the additional activity coming through. In NHS Highland, there was a 30 per cent reduction from the peak over the year immediately prior to Covid. The board was performing exactly as we wanted against the plan. As Pam Dudek said, the latest unpublished statistics, which are for August 2020—they will need to be verified before they are published—show a figure of 100 per cent against the 31-day cancer standard.

For the rest of Scotland, part of our remobilisation plan thinking is about how we apply the capacity that we have in order of clinical prioritisation. We have adopted the Royal College of Surgeons clinical prioritisation methodology, which has categories running from priority 1 to priority 4; I can send you some detail on that if you want.

Although there has been a growth in waiting lists and waiting times in the past six months, I can now see the signs of recovery, and the lines on the graph beginning to turn, across Scotland. Looking forward to winter, we need to plan for three factors. The first is a potential growth in Covid again. Secondly, there is a significant drop in productivity, as I would put it, in the health and social care sector because of social distancing, spacing and so on, which has taken some capacity out of the health service. We are alive to that, and we are doing what we can about it by

transferring patients to digital consultations. Thirdly, we also have to plan for winter. All those things are coming together in our thinking about how we engage across all health boards and offer them mutual support.

The Acting Convener: I will hand over to Colin Beattie, who is joining us remotely.

Colin Beattie (Midlothian North and Musselburgh) (SNP): First, I note that the Audit Scotland report is almost a year old, and the data and information in it is well over a year old, so a great deal of updating is needed. However, it contains a few items that are worth picking up on.

I have been on this committee for nearly 10 years, and NHS Highland has featured again and again. We have sat here with the chief executives, the board members and the chair of the board, and we have received all the reassurances that everything has been put in place and it is all going to be fine. Lo and behold, a year or two later, it all crashes and burns again. Why will it be different this time? There has been a significant change in the governance: in the leadership, the board of directors, the chief executive and the chair of the board—it is a clean sweep.

This is not the first time that we have heard about these issues. Why is it going to be different this time?

The Acting Convener: Who wants to pick that up? Pam Dudek, do you want to come in?

Professor Robertson: I will pick that up initially, convener.

The Acting Convener: Apologies—I will bring in Professor Robertson.

Professor Robertson: It will be different this time because we have new leadership in place. That in itself will not guarantee the step change that is required, to which Mr Beattie referred. However, I can assure him that the team that is now in place is determined to rectify matters. Indeed, we can already show an improvement in our finances.

We achieved a £28 million saving target last year, and we exceeded that in 2019-20. We achieved that by having a project management office in place and we also had external consultants, who were helpful in that process. With that project management approach, even allowing for Covid and the turbulence that it has caused, we are making good progress towards our substantial savings target for this year. Although we will still require brokerage, as agreed with the Scottish Government, we are on track. Pre-Covid, we were very confident of achieving our three-year target of breaking even next year.

I will ask my colleague Pam Dudek, and possibly also Mr Connaghan, to speak to that as well.

Pam Dudek: I appreciate the question. There is an element of its having yet to be demonstrated under my leadership. I came in on 20 April as deputy chief executive for a short period. What I have seen is that the robustness of the governance, the project management approach, and an embedded methodology not only at a senior level but with engagement right across the system has put us in a very strong position to have strong surveillance of what we are doing and of what we are delivering, to know where our issues are—we are not, as everybody knows, without issues—and to move forward confidently as we—[*Inaudible*.]—in terms of the achievements of the last year.

Colin Beattie: With respect, we have had reports previously that outlined all the issues. From what I see from this report, it has not changed—there are still the same issues. Why will it be different this time?

The Acting Convener: I will perhaps put that to Mr Connaghan.

Pam Dudek: It is still myself—

The Acting Convener: I will ask Mr Connaghan to respond to that and then perhaps come back to Pam Dudek, if she wishes.

John Connaghan: The heart of that question is to say that it is fine to have a plan, but can we demonstrate progress against that plan? I know where the question has come from, in that we in Highland have, over the past number of years, described a process. However, we can take comfort in a number of ways. For the first time in NHS Highland, we have had, over the past two years, an improving position in two ways.

First, there is the financial position, on which I think that the committee needs to be brought up to speed. It is absolutely right to say that this is the 2018-19 audit, but we need to think about what happened in 2019-20, and we might also want to consider the plans for next year. Examining all that—if we have the time—will give the committee some degree of assurance that we are on a sustainable—

The Acting Convener: Tell us about the financial progress that was made in 2019-20, Mr Connaghan. That is why we have you here. Tell us what that progress is.

John Connaghan: I will bring in Richard McCallum, the director of finance, who will give the committee some facts and figures on that.

Richard McCallum (Scottish Government): To pick up on Mr Beattie's question, one of the key

things from our perspective is that we are starting to see the evidence of improvement that NHS Highland forecast.

When the Auditor General reported last year, she noted that the trajectory was for £11 million of brokerage in 2019-20 and returning to financial balance by 2021-22. In 2019-20, NHS Highland achieved the financial trajectory that it set out. It got to the £11 million deficit that it planned on, which was achieved—as Professor Robertson described—through £28 million of savings. The board is therefore taking steps and is on the trajectory that the Auditor General updated you on last year.

As Mr Robertson said in his opening statement, one of the more encouraging things from a finance perspective is that, where there were savings of 29 per cent in 2017-18, the board is now making recurring savings of around 60 per cent each year. There have therefore definitely been improvements in financial planning and performance over the past year or two.

10:00

Colin Beattie: Perhaps I can ask a question about leadership, because this whole thing rotates around leadership, which has been a recurring problem in NHS Highland. I will ask a simple question: why is it so difficult to recruit adequate leadership both on the governance side—the board—and on the operational side?

The Acting Convener: Is that a Scotland-wide question or a specific NHS Highland question?

Colin Beattie: It is specifically for NHS Highland, because it has been evidenced over a number of years now—going back almost 10 years—that there have been repeated failures at different levels of leadership in NHS Highland.

The Acting Convener: I think that that question would be best answered by the chair.

Professor Robertson: I am happy to take that question. There has been an improvement in recruitment to NHS Highland in the recent past and we can supply you with very detailed figures on that—for instance, the recent recruitment round for our new chief executive attracted 15 applicants. Five highly qualified applicants from across the UK were shortlisted and Pam Dudek was the successful candidate, with a strong track record in health and social care in Moray in particular. We have also more recently advertised for a director of estates and have appointed to the post, which is a new post for us, and that attracted more than 50 applicants. We have appointed a head of communications and engagement and, again, we had a substantial list of applicants; we had to have a long list of 10 before we reduced it to six for final interviews.

That indicates that confidence is building in the NHS about the performance of NHS Highland and about the opportunities to take forward that programme of reform and transformation. Performance, as well as culture and finance, is part of the programme of transformation that we have embarked on and are making considerable progress on. I assure you, Mr Beattie, that we are intent on improving the situation and you will see from the 2019-20 audit report that it is a much improved picture.

Colin Beattie: Could I ask the Scottish Government to comment on the leadership question from a historical point of view?

John Connaghan: That it is a fair question. In the past few years, we have established a leadership training programme called the Project Lift programme, which will take some time to work its way through. If I was going to be self-critical about our position across Scotland, I would ask whether we had done enough to nurture talent, make jobs attractive and establish a training programme to prepare those at middle management level for top management posts. I hope that our Project Lift programme will stand us in good stead in the future.

We had some concerns in some of the recent audits about the attractiveness of Highland in terms of the confidence of people applying for clinical jobs, because we need clinical leaders as well as management leaders. I had a look at the five-year history in preparation for this meeting. In the five-year period to March 2020, there was a 21.5 per cent increase in the number of consultants—the head count—in Highland, a 10 per cent increase in nursing and a 12 per cent increase in allied health professionals. Some things are working in Highland. We are beginning to attract clinical leaders and consultants, and we need to do the same by supporting our middle managers to take top management jobs as well.

Colin Beattie: That is fine on the operational side, but what about the governance side, which has historically been a problem in NHS Highland?

John Connaghan: I ask Boyd Robertson to comment on the most recent non-executive position and how we have strengthened that in Highland. It might be more appropriate for him to talk about the local detail.

Professor Robertson: There were three new board members in July last year. We are in the midst of a recruitment round, and we will have interviews shortly. There has been a very high level of interest in those posts. There are three non-executive posts to be filled on the board, and I am confident that we will get people with

expertise, including expertise in finance, to fill those places.

To return to Mr Beattie's question, there has been a lot of activity on the governance front. We have put in place a revised, streamlined governance structure with a much more effective framework and regularisation of reporting routes into the board. We have put in place revised terms of reference for the governance committees and introduced an integrated performance report and a board assurance and risk framework, which comes to every board meeting. We had a board meeting last week, and that was the first time that we had those reports before us. That worked very well.

We have appointed a dedicated risk manager, and our governance committees have been refreshed. Each committee has to appoint a vice-chair. We have reinstituted a system of meetings of chairs of the sub-committees, and that is proving to be very effective. I have formal weekly meetings with our chief executive as well as catch-ups. There are formal weekly meetings with the chief executive, the deputy chief executive and my vice-chair.

We have implemented many initiatives to improve our governance structures.

Colin Beattie: Finally, there is one thing that I noticed that is absent from the report—I do not know whether I have missed it. There is no mention of Raigmore hospital in it. In the past, concerns about its financial situation have featured heavily. It featured heavily in the apparent overshoot on prescriptions, which the report mentions, but it seems to have vanished as a major item. Is it now deemed to be regularised? Is it now back under control? Are the costs there now being contained?

Pam Dudek: We have rigorous oversight of every part of the system, and all the parts are interdependent, so looking at one part in isolation is always tricky. However, we have seen a significant reduction in the drug costs at Raigmore hospital. I think that that cost pressure was £3.6 million in 2018-19; it is now down to £0.9 million, and we continue to look at prescribing. Raigmore hospital's budget is very stable at the moment, and it is not running with the overspend that it was running with. However, as members will appreciate, we are continuing to understand the impact of Covid and what is a result of regularisation.

Much of our cost improvement plan is focused on aspects of care delivery and processes that are associated with the acute hospital. A fair bit of redesign in there will have contributed to that cost improvement, from workstreams that are related to Raigmore, and it is certainly in a much more stable position.

As with all budgets, it is under our constant surveillance, with a close eye from our weekly financial recovery board.

John Connaghan: One of the things that we need to recognise about Raigmore is that, for many years, it operated with what I would call a deficit in its infrastructure, in that it did not have an effective modern unit for day-case surgery procedures. As you can imagine, the operating model in NHS Highland of putting day cases through main theatre, let us say—which is the most expensive hour that you could ever buy in the healthcare system—is inefficient and unproductive.

Some years back, in recognition of that, we provided the funding for an elective centre that will give NHS Highland and Raigmore a new, more modern and sustainable lease of life. However, in the past few years, the Scottish Government has decided to act in advance of that elective centre coming on stream by funding additional mobile day-case surgery theatres.

We have altered the model of care. It is more sustainable. We are more productive now in NHS Highland and Raigmore than we have been in the past. Of course, we will need to see what happens when we eventually come out of Covid, and pick up again the threads of all of that.

Colin Beattie: Thank you.

The Acting Convener: There is a request from Willie Coffey, who also joins us remotely, for a supplementary question.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): It is a wee question for Professor Robertson, probably.

Richard McCallum said that £28 million of savings had been made. I want to ask about the consequential impact on services. It is very welcome that you are bringing the finances back to target, but you cannot spend £28 million last year and not this year with no consequential effect on service delivery. Will you tell us how that has gone?

Professor Robertson: You are right to say that savings measures such as grip and control have had impacts. They are not universally popular. They may also play a part in cultural issues and in interactions at the coalface—at the ward level. However, in general, they have been achieved with a real degree of acceptance.

Our chief executive can comment on more specific matters.

Pam Dudek: I can understand the concern that has been expressed, but all the savings that we

have made—63 per cent recurring—have been developed through our cost improvement plan programme of work. That is driven by our key clinical leaders and managers who are working on the front line.

The ideas for savings are generated from the front line, through the programme management office process, and are then tested fairly rigorously, through a process, before they come to fruition and are deemed suitable to take as savings. Part of that process involves a quality assurance check, at the helm of which sit our director of nursing and medical director.

Quite often, the changes have been to potentially inefficient processes, or in the ways in which we work; that has a consequential saving.

Willie Coffey: So, there has been no major impact on service or quality as a result of a saving of that magnitude. Is that really what you are saying?

10:15

Pam Dudek: It is. The savings that have been made have been completely checked—there is a five-step check, the results of which are not taken lightly. Clinicians and managers on the front line are at the heart of it. There is also another level of quality assurance through our lead clinical governance executives.

Graham Simpson (Central Scotland) (Con): I want to go back to the issue of staffing. The report mentioned unfilled vacancies, which we briefly discussed earlier. How many unfilled vacancies are there in NHS Highland at the moment, and in what areas are they?

Pam Dudek: I do not have the number of unfilled vacancies in front of me. I have our vacancy and turnover rates. In 2019, the turnover rate was sitting at 10 per cent and it is now at 7.7 per cent. Our vacancy rate was 9.2 per cent overall, and that is now down to 7.9 per cent.

The general turnover in nursing looks consistent with the month's notice that nurses have to give. The 2019-20 rate was around 8.4 per cent, and the vacancy rate across registered nursing is now sitting at 6 per cent, which I believe is reasonably consistent with the rest of the country. Our vacancy rate for medics has gone from an average of 11.8 per cent down to 9.5 per cent.

In recent weeks and months, we have made significant progress on some of our hard-to-fill consultant posts. The acute sector associate medical director has reported very positive progress on that.

Graham Simpson: Those percentages do not mean a great deal. Can you put numbers on them, and can you say in which areas you are short of consultants?

Pam Dudek: There were some difficulties in particular areas, such as ear, nose and throat. We have made progress there. We had some general physician vacancies—particularly for rural general hospitals—and we have made progress there, too.

Indeed, some of those people have come to us with additional specialities—one consultant is a specialist in pain management, which is significant for us. Therefore, it is not necessarily only about what they come into a post as. If they are, say, a general physician in a rural general hospital and they also have some additional skills, we will manage to tie those up.

I would be happy to produce a briefing that gives you the specifics.

Graham Simpson: That would be useful. It would also be useful if you could break it down a bit and show us what the situation is in each part of NHS Highland .

I have another question, which is really on the same issue. The report says:

"As part of the recovery plans a programme management office ... has been set up to oversee a programme of service transformation and financial recovery plans. A procurement exercise was run to appoint a permanent PMO director."

It then goes on to say that you did not find anyone and that the board decided to appoint PricewaterhouseCoopers instead, and that you awarded it a contract that cost £1.2 million including VAT. How can you justify spending that sort of money on consultants? You could have employed 10 or more PMO directors for that money. Where is the justification for that?

Pam Dudek: I was not in post at that time, but my understanding is that the requirement to bring in the capability and capacity for us to make the change, which has been evidenced, was the real driver for taking the decision. That was part of the support package that was agreed to move NHS Highland forward on to a positive track.

The consultants provided the methodology and the ability to train people up and embed a different way of managing transformation and finances, and we have seen the results, which were doubted in the section 22 report. The statements in the report that I read suggested that achieving those results was perhaps unrealistic. Although I recognise the size of that cost, given the task that was ahead, the money has shown a return in relation to improved performance and the capability of our system.

Graham Simpson: Is the contract still running?

Pam Dudek: We now have the capability in-house, and we are running that from a Highland perspective. The contract with PwC has been completed.

Graham Simpson: I have no idea what any of that means. What does "Highland perspective" mean? Have you appointed anyone?

Pam Dudek: It is now in-house. We now have it embedded within NHS Highland.

The Acting Convener: How much does it cost NHS Highland to do that in-house?

Pam Dudek: I do not have that figure in front of me. I am sorry.

The Acting Convener: Can you work out the cost and send the figure to the committee?

Pam Dudek: I am sure that we can.

Graham Simpson: To be clear, you are no longer employing PricewaterhouseCoopers. Is that correct?

Pam Dudek: Yes.

The Acting Convener: I ask Mr Connaghan to reflect, from an NHS Scotland perspective, on whether the £1.2 million cost was acceptable.

John Connaghan: My reflection on the £1.2 million cost is that, from what I understand, the PwC work went a lot wider than just the PMO and project management skills. It was at the heart of addressing governance issues and identifying how the system could change, as well as being used to inject good PMO skills. The proof of the pudding is in the eating. Is what PwC brought to NHS Highland delivering results? We have already heard that it is.

The Grant Thornton NHS Highland final audit report for the year ending March 2020 is yet to come to the committee, but the report found that, although the board faces significant challenges, it has demonstrated progress in addressing the previous findings. We need to look at the issue not just from the narrow perspective of the PMO but by considering the wider, sustainable and multiyear impacts of the work of PwC in that respect.

The Acting Convener: We have a request to ask a supplementary question from Alex Neil, who joins us remotely.

Alex Neil (Airdrie and Shotts) (SNP): I have a couple of quick questions that arise from what has been said. First, can Pam Dudek send the committee a breakdown of the daily rate that the consultants charged? I used to be a consultant, and £1.2 million seems to me to be a hell of a lot of money.

Secondly, can NHS Highland point to where the return was? I take what John Connaghan said about there having been progress and so on, but we want to see proof that that progress was a result of spending £1.2 million on PwC. Can we have those two bits of information? I realise that the information is probably not available just now but we should be furnished with it because I think that the public are getting fed up to their back teeth with consultants being paid film star rates when there is no obvious benefit to the public sector, not just in the health service but across the public sector.

Pam Dudek: Yes, I can look into providing a briefing on that. The other observation that I would make about the capacity and capability that has come out of that set-up is that we were able to restart our savings and our remobilisation fairly swiftly, even amidst Covid, because of the capability that had landed in the system. Some of that is not seen as a financial return; it is about how we are able to step up and do our jobs, even within the context of a challenging time with Covid.

The Acting Convener: Thank you. If you could give us a more detailed breakdown of what exactly was commissioned and the cost, that would be helpful.

Professor Robertson: One of the benefits of PwC was the training that it provided, not just to the executive cohort within NHS Highland—particularly to those who were recruited to our internal PMO—but at board level, where PwC provided us with training on finance and how to evaluate our finances. That was a very productive session for the board.

John Connaghan: It might also be useful if, as well as furnishing that information on PwC, NHS Highland could provide the committee with a copy of its remobilisation plan for the course of the next year. That would give the committee sight of what plans NHS Highland is laying out for the future and what it hopes to achieve. The committee can look at those future plans as well as looking back.

The Acting Convener: Just to clarify, Mr Connaghan, the PwC contract has ended, so the remobilisation plan was done in-house. However, the skills that were learnt the previous year from the PwC contract helped to deliver the remobilisation plan, although PwC was not involved in the plan. Is that correct?

John Connaghan: You are absolutely spot on and I think that if the committee could see the fruits of that work, which are embedded in-house, that would be useful.

The Acting Convener: I believe that Pam Dudek wants to come back in and then we have a request for a supplementary from Colin Beattie.

Pam Dudek: Just to reiterate, there was a quick and responsible restart of the activity around financial recovery and performance recovery in the post-Covid period. That came from the front line, from our teams, and their capability and understanding of the process allowed us to motor ahead; you will see the fruits of that in the document.

The Acting Convener: Thank you. As part of that breakdown, it would be helpful to see what skills are now in-house that PwC provided and how much it costs in-house to provide that same service that PwC provided for £1.2 million. I think that the committee would be keen to see that information.

Pam Dudek: Absolutely.

The Acting Convener: Colin Beattie is next.

Colin Beattie: Sorry, convener—I did not request a supplementary.

The Acting Convener: My apologies—I got the wrong information from our clerks. I will now hand over to a patient Bill Bowman.

Bill Bowman (North East Scotland) (Con): Thank you, convener. I want to stick with governance. The section 22 report highlighted areas in which the board's governance arrangements needed to be developed. In particular, it noted that

"the audit committee needed to be substantially strengthened within NHS Highland's governance structures."

The report also said that the auditor noted that

"at the time of producing the annual audit report, 102 internal audit recommendations were overdue."

What progress has been made in implementing those recommendations? Secondly, what action has been taken to strengthen the board's audit committee? By way of background, or as a reminder, during our evidence session in November 2019, the auditor advised us that although

"The chair of the audit committee has a financial background ... The other individuals on the audit committee do not have governance, risk management or financial backgrounds."—[*Official Report, Public Audit and Post-legislative Scrutiny Committee,* 14 November 2019; c 19.]

10:30

Professor Robertson: On the point about strengthening the audit committee, as I indicated earlier, we are recruiting three non-executive members to our board. We have stipulated that at least one of them must have a finance or audit background. We would intend to deploy that person to the audit committee.

As regards the committee itself, the outstanding actions have been reduced from more than 100 down to 14. Solid and substantial progress has been made in addressing the backlog that the committee faced. The chair of the committee is intent on driving that number down to single figures.

Bill Bowman: So, after all this time, you are still looking for what we might call qualified members to sit on the audit committee. Is that what you are saying? I thought that the comment about the lack of governance, risk management or financial backgrounds was quite a damning one, and the report was produced a long time ago.

Professor Robertson: We also had a recruitment round for the board last year, and one of its new members has a high level of experience of working in similar situations with the UK Atomic Energy Authority. We have strengthened the audit committee already, and we will have done so again by the end of this year, when we will have the new board members in place.

We have also appointed a risk manager to the board in the past year to examine our overall risk audit, and we have put a board assurance framework in place. That is one of the new initiatives that have been taken to give our board more assurance around audit at all levels of the organisation.

Bill Bowman: [*Inaudible*.]—to appoint somebody, have you done any training for the audit committee?

Professor Robertson: Yes, we have had members of the audit committee trained, and we have plans for training the new members who will join the committee. As a board, we have had training in aspects such as finance, risk management and asking challenging questions.

Bill Bowman: I looked at your website to find the audit committee minutes. First, I noted that, in the audit committee section, the most recent minutes that had been posted were from December 2019. After digging around, I found that the audit committee papers seem then to have been subsumed into those of the main board. I do not think that that necessarily gives the committee the prominence that it needs.

To return to what you said about the risk assurance framework, I looked through the main papers and saw that it came to you in September. I was not quite sure what it was. Do you have a risk register that is separate from the framework?

Professor Robertson: Yes, we have a risk register. What comes through to the board via the committee structure and the audit committee is the high-level risks for the organisation as a whole—the strategic risks for the organisation.

Bill Bowman: What are the top three risks for the organisation as a whole?

Professor Robertson: We have discussed many of them today; finance is one of them.

Bill Bowman: What are the top three on your risk register?

Professor Robertson: Finance is foremost. Another risk area is the culture and our response to the Sturrock report. Our performance, which has been discussed already, is a third risk area.

Bill Bowman: Is that the order that they are in, or were you just telling me what you think the main risks are?

Professor Robertson: Those are the overall areas of risk. I would have to refer you to the risk register itself, and I would be happy to offer you that.

Bill Bowman: Can the chief executive tell us what the top three risks are?

Pam Dudek: As Boyd Robertson said, there are three top risks that are really significant. Actually, there are four—workforce is another. The culture component is clearly a big feature for us, as are finance and performance. We have work to do in all those areas, and they are still considered to be high risks for us. Finance is very high on the list.

Bill Bowman: It would be helpful if you could send us the register, so that we can make a comparison. I would have thought that Covid would have been on your risk register.

Pam Dudek: It is. We live with it every day and it cuts across everything that we are doing. However, dealing with the sustained incident of Covid goes alongside ensuring that we have a sustainable, forward-looking and safe organisation; it hangs around the key pillars that we have mentioned.

Bill Bowman: The chair mentioned all the different meetings that you are now having. Expressions such as “blinking meetings” have been used. How do you ensure that good communication comes from those meetings, and that they are not just meetings?

Professor Robertson: The minutes of the meetings are submitted by the audit committee to the board. At each board meeting, we receive a copy of the minutes of the audit committee. In addition, we have the chair of the audit committee at board meetings, who highlights significant issues that have been discussed at the audit committee. I also sit in on meetings of the audit committee on a regular basis.

Bill Bowman: Convener, perhaps we could get a copy of the risk register?

The Acting Convener: I think that Mr Bowman is making the point that priorities and risks are two different things. Priorities are a separate issue. If you could share your risk register with us, that would be very helpful in giving Mr Bowman the additional information that he is looking for.

I believe that Pam Dudek wants to come in.

Pam Dudek: I want to contribute on the communication aspect of Mr Bowman’s question. We continually look at our communication outwards and inwards and how we do that. There might well be room for improvement in the visibility of the information from the organisation.

Bill Bowman: I have one final question. This would obviously be subject to the need for social distancing, but does the chair or the chief executive walk the wards from time to time to hear what is going on?

Pam Dudek: That has been very difficult during the Covid period, because in order for staff to feel safe and be protected, there was a level of support from leadership and management, but it was also agreed that it would be better if they were allowed to get on with their jobs, with appropriate support, and we did not put people at risk by bringing additional people into front-line areas. However, in the post-peak period, walkabouts have started. We are looking to improve on that in the coming months, but that will be hampered at times by the situation with Covid.

We have used a lot of virtual means to reach the front line. For instance, when we were developing—[*Inaudible*.]—we used the Teams platform to run workshops and to reach out to people on the front line, so that we were able to develop the plans together and to connect with our front-line staff.

I have certainly been across to and started walkabouts at Raigmore hospital, and I will connect with Argyll and Bute next week. As long as restrictions do not—[*Inaudible*.]—I plan to be as visible as possible to colleagues, in person—or, if that is not an option, remotely.

The Acting Convener: Professor Robertson mentioned the issue of culture and bullying. I turn to Alex Neil MSP, who I believe wants to focus on that area, and who is joining us remotely.

Alex Neil: Before I come on to the follow-up to the Sturrock report, I want to say that I have been impressed to hear about the progress that has been made on things such as finance, which is extremely important. However, the most important area of performance for the health board—which uniquely in Scotland is also the single agency for social care as well as for health—are the key performance indicators for health and social care.

I realise that we cannot go into every one of those, but will Professor Robertson and Pam Dudek give us a brief overview of NHS Highland's progress on the top five or six key performance indicators, and then will John Connaghan give an additional perspective and compare NHS Highland's recent performance in those areas with performance across Scotland?

Professor Robertson: I ask Pam Dudek to come in on that.

Pam Dudek: We have the lead agency in Highland, and the integration joint board in Argyll and Bute, and the performance indicators will link to both.

When it comes to the management steering group objectives, the key indicators include delayed discharges and the impact that unscheduled care has at the front door of the hospitals; that is a big part of the indicators. We have quite a lot of work under way to look at how we get something more robust on delayed discharge in the north Highland area because, during Covid, we were very successful in caring for people at home. Obviously, we moved staff around to try to deal with the incident, which gave us different capacity in different places to do different things.

We are of course trying to learn from that approach. As we work on our winter planning, which we are doing this month, we are looking at what aspects of that we can sustain. Traditionally, that area has done reasonably well, but it had a slight challenge as we were coming out of the Covid era. Again, staff are working hard, and we scrutinise that weekly with the community teams.

On the wider health and social care agenda of mental health and learning disabilities, we have a varied picture, and certainly room for transformation and change in some of those areas. Clinical and social work practitioner leads are working together to consider what the future might look like. Some of that is in our remobilisation plan, and some is very much about our strategic direction as we look to the future. Obviously, that will be in the context of the national frameworks on mental health and learning disabilities.

There is some very good work and there are some very good outcomes for people, but the situation is variable, and I would like to focus strongly on that—obviously, my background involves that as one of my main focuses. I see room to strengthen that, and room for change, redesign and modernisation.

10:45

John Connaghan: I will make some brief comments on that. On Mr Neil's theme of four or five key indicators, Highland in the main compared pretty favourably with the rest of Scotland on compliance with the four-hour accident and emergency standard for unscheduled care. As members know, most of our problems in delivering the four-hour A and E standard were in the central belt. Nonetheless, Raigmore hospital is big—it serves the Highlands—and it compares well on that against the rest of Scotland.

I have already referred to out-patients, which is the second issue that I was going to raise. There has been a 30 per cent reduction from a peak of 14,000 on the waiting lists in mid-2019. Immediately before Covid, we observed NHS Highland reducing that number to around 9,500 by mid-2020.

I have already referred to the 31-day cancer performance target. The unpublished data for August, which will be published shortly after validation, is 100 per cent. It cannot get better than that.

On the other cancer standard, which is a 62-day target, NHS Highland struggles in the delivery of urological cancer services compared with the rest of Scotland, and it is aware of that. That is connected to cystoscopy services. It has an action plan on that, and we can see that backlog reducing.

Those are the main acute service indicators that I would cite at this stage. One of the audit reports said—I cannot find this at the moment—that Highland compared reasonably favourably with the rest of Scotland. If members need more details on that, we can pull out the statistics and send them to you.

The Acting Convener: It is interesting that you quoted the figure of 100 per cent. That is, of course, very welcome, and you cannot get better than that. However, you did not quote the figure for the 62-day target, which is 62 per cent, which is nowhere near good enough. Diagnosing cancer is one thing; treating it is another. The figure for meeting the cancer treatment target is only 62 per cent, not the 100 per cent figure, which relates to referrals. Therefore, there is still work to do.

Alex Neil: That is a fair point. However, generally, it seems to me that the performance is improving somewhat. Obviously, that was particularly the case pre-Covid.

NHS Highland is unique in the sense that it is the single agency for health and social care in Scotland. This question is for John Connaghan. On performance—I am talking primarily about health and social care outcomes—is there a

discernible difference, positively or negatively, between NHS Highland's performance as a single agency and the performance in the other areas, none of which has a single agency?

John Connaghan: Comparing with the rest of Scotland is exceptionally difficult at this stage because of the lack of comparable data across Scotland. There are issues that members may want to go into, such as how budgetary issues will be resolved in the delivery of social care in Scotland. There are measures that I do not have to hand but on which we could provide information.

Pam Dudek has an integration background. She worked in a different position, and she now works in Highland, so she is perhaps the best person to give you an answer to that.

Alex Neil: It would be useful if Pam Dudek gave an indication of her perception, because the issue is important. If we are to get health and social care properly integrated, we need answers to such questions. We have operated both models—the Highland model and the rest of Scotland model—for a number of years, and we really need to get the data. Policy makers and audit committees need that data to know what is the best way forward. Pam, you have experience from both sides of the fence, so what is your take on that?

Pam Dudek: It has been interesting for me to come into the system as it is with the knowledge that I have. First and foremost, one of the challenges that we have in many areas across Scotland—I am speaking from my experience as a chief officer—is having the suite and the level of data from across community services to be able to prove the outcomes. Most integration authorities are trying to develop and improve on that, because the balance of activity that happens daily across our communities is huge, and many factors relate to that. That is one aspect.

On the models, I suppose that, as with anything, there are pros and cons for both. In terms of the structure of the governance, a single agency model perhaps has a slicker governance route, day to day, and that is what I am seeing. However, it is fundamentally based on the premise that partnership working is worthy and on being able to bring the right level of interest and skills from the multi-agency approach to deliver good outcomes for people.

From what I can see, the fundamentals of integration are still the principles that are adhered to in both models. With IJBs, perhaps there is a little bit more push around the commissioning aspect, because of the nature of that additional public body. However, we are in the process of reviewing our scheme of integration.

I guess that a question that is sitting in the wings is whether we should operate the same model as everywhere else or whether we should pursue, improve and strengthen the existing model. Both models are predicated on partnership working. A structure is a structure. The issue is how we work together.

Alex Neil: That is interesting, but following it up is probably for another day.

I revert to my original concern about the implementation of the Sturrock report. Clearly, that report indicated a disturbing culture operating in NHS Highland. I do not think that that was unique to NHS Highland, and other people are perhaps looking at the lessons from the report. Where is NHS Highland in implementing it? Does a better culture operate now? How much further is there to go? Are both the health and social care sides covered? It seems to me that, if we are going to operate an integrated service, the issues cut across health and social care.

Professor Robertson is probably best placed to answer that.

Professor Robertson: I am happy to take that. The response to Sturrock is a long-term initiative. We are on a journey. The culture of an organisation cannot be transformed overnight, and it is more important that we put in place the right measures than it is to act hastily.

After the publication of the report last May, I listened to more than 20 of the people who were involved and harmed by the experiences that they had endured. I was really taken aback by what I heard, which corroborated what John Sturrock had revealed in his report.

I considered that listening exercise as being important to gauge and understand fully what had happened. I went around our region, to health centres, hospitals and care homes. I went to more than 30 locations throughout our extensive area, which covers more than 40 per cent of the landmass of Scotland, to take the temperature of the organisation.

We carried out 23 staff engagement exercises throughout our region, which involved listening to the views of our staff on what was in the Sturrock report and what could be done about it. We have put a number of measures in place. For example, we established a culture programme board and appointed an external culture adviser; I was keen that it should be someone independent and external to the organisation. That person now chairs our culture programme board.

We have also put in place courageous conversations training for our staff, and I am happy to say that 500 staff have engaged in that programme. Other measures for staff include an

employee assistance programme, which is run by a company called Validium. It has been active from May this year, and in the first three months it received around 40 calls, 16 of which were about accessing counselling or other support. In August this year, we established a freedom to speak up guardian service, which, like the employee assistance programme, is a 24-hour, seven-days-a-week service. During August, there were 51 calls and 68 emails to the guardian service; 32 cases were raised and 17 have already been closed.

An important part of our response has been the establishment of an independent Healing Process service, which was co-produced by our human resources department, our staff side and, importantly, the whistleblowers. As part of the engagement process, I meet regularly with senior executives and a whistleblower group to temperature check and sense check what we are doing. The Healing Process service is independent—it was launched in May, and the first cases are now coming through to the remuneration committee, which I chair. We have had extensive support from the Scottish Government for that programme.

We have also had a review of culture in Argyll and Bute—I suppose that that speaks to the health and social care service covering that area, which is run by the integration joint board. A company called Progressive Partnership carried out a survey for us at the very end of last year and the beginning of this year. John Sturrock recommended that we undertake that piece of work, because he had not been able to interact sufficiently with people from Argyll.

The survey findings corroborated John Sturrock's findings but, worryingly, they indicated that some of the cultural behaviours that had been identified in the report were still in place, so we had to address that very quickly. We did so by establishing another culture board in Argyll, which developed an action plan. I am happy to say that 30 members of staff in Argyll volunteered to join the local programme board.

We have made substantial progress in the year and a half since Sturrock reported. Some might criticise us for not moving quickly enough but, as I said, we wanted to take a considered view and to get things right as far as possible so that our process can be a template for other boards in Scotland. Covid has intervened, of course, which has paused some of our activity.

11:00

Alex Neil: That sounds comprehensive and impressive, Professor Robertson, and is to be welcomed.

This is my final question, convener. How is the board measuring the success of the outcomes? For example, it is clear that a key measurement is the reduction in the incidence of bullying and harassment and associated activity. All those initiatives sound good, but, at the end of the day, are they working?

Professor Robertson: You are right—the metrics around that are not easy. In the past 12 months, for example, we have had 39 cases of bullying raised, 14 of which have been resolved. That is one measure of what is happening at ground level.

Last week, our national whistleblowing champion—he was appointed to the board by the health secretary—told me that he has had no representations from members of staff, which is another of the measures. The statistics that I gave around the employee assistance programme and the guardian service also indicate the levels of concern and any issues that staff have.

Those are just some of the metrics that we have. There may be a need to survey staff a year on to see what is being achieved and to sense check everything that we have done.

Neil Bibby (West Scotland) (Lab): I have a couple of questions on staffing. NHS Highland has had high medical locum costs over a number of years: £15.6 million in 2018-19; £14.9 million in 2017-18; and £14.7 million in 2016-17. It was also reported that £1 million was spent on two locum doctors. What is the current situation with locum costs? What action is being taken to reduce those costs?

Pam Dudek: We have taken a range of actions. Clearly, recruiting permanent staff to those posts is a key action and, as I said, our experience of that has been different in recent months. Last year, we removed 14 of the 20 highest-paid locums. Since then, we have removed five more.

When the issue was looked at previously, a couple of locums of particularly high cost, both of whom are not with the organisation any more, were replaced. One was replaced with a substantive post.

When we have to use locums, our actions on reducing costs are focused on using the NHS framework for locums as opposed to using agency locums. We have an improving picture, and we are fully scrutinising that. An issue that we have in relation to the costs and how they present is the balance between the hourly rate and the number of hours that people work in terms of being on call and so on, and that is reflected in the level of work that is asked of them.

The Acting Convener: I think that Mr Bibby asked for the actual figure. Do you have the figure for him?

Pam Dudek: I am sorry, but I cannot give you the figure right now—I wrote it down, but I do not have it in front of me. I will give it to you in a couple of minutes.

Neil Bibby: There have been high medical locum costs and, even if things are moving in the right direction, I suspect that the figure will still be significant. I want to press you a bit more on that. Why is there, or why has there been, a need to spend so much on locums? If there has been progress on recruitment—you have said that there has been—why has that spend happened?

Pam Dudek: In general, locums are engaged when we do not have the staff to cover areas that are felt to be critical to service delivery. In those circumstances, we have little choice but to use locums in order to deliver the service. The most likely reason for not having staff cover is being unable to recruit to a substantive post, but the other main reason for using locums relates to sickness and absence.

Could you repeat the second question? I am sorry, but I am not sure that I fully understood it.

Neil Bibby: You suggested that progress has been made on recruitment. What are the reasons behind that?

Pam Dudek: We are trying to capture what has changed. I do not have that information in any factual form at this point, but we are asking the people who come into posts what has attracted them to work for NHS Highland. We have some thoughts about the fact that people are making different judgments about how they might live their life in the wake of Covid, because there has been substantial interest in posts in the Highlands. Given the rural setting and the dispersed population, people might feel that the Highlands is a safer place to be, so we have that offer.

However, I hope that people are also taking posts because some of the jobs are extremely attractive. There is a fair degree of innovation about how to run the best possible services among the clinicians whom I have met—there is huge motivation there. I would like to think that that is an element of the appeal.

As people come into the posts, we will capture what attracted them to the jobs, so that we can try to understand what has changed. I will use myself as an example. Why did I go for the post of chief executive of a board that looks quite troubled and requires a lot of work? I did so because I could see some of the progress that had been made and, by speaking to people, I could see the motivation in and potential of the organisation.

The Acting Convener: Have you found the figure that we asked for?

Pam Dudek: It is £18.1 million.

The Acting Convener: Is that the figure for 2019-20?

Pam Dudek: Yes.

The Acting Convener: That sounds higher than the figures that Mr Bibby cited for previous years. In your original answer, you said that progress had been made, but the figure is now higher.

Pam Dudek: I will have another look at the figure. I will inform the committee of it and the rationale behind it.

The Acting Convener: It worries me that you feel that progress has been made but the figure is higher. You said that nine of the highest-paid locums have been "removed"—that was your word. Do you mean that full-time NHS staff have been recruited as replacements for the locums, or did you just remove the locums?

Pam Dudek: I am sorry. Can you say that again?

The Acting Convener: You said that the nine most expensive locums have been "removed"—that was the word that you used. Was that because NHS staff were recruited to replace those nine locums, or did you just recruit nine cheaper ones?

Pam Dudek: It was a mixture of recruitment and people being moved on to a different contract. There are still locums in some of the areas, but they are on an NHS locum contract as opposed to being employed through the agency, which is more expensive. It is both. We have not managed to stop using locums completely, and—

The Acting Convener: If you could share some analysis of how a rising figure is an improvement, that would be greatly appreciated by the committee.

Pam Dudek: I will do.

Professor Robertson: I will add some local flavour to the point about workforce. A series of locums had been operating the three practices on the Isle of Mull, but those have now been replaced with a permanent arrangement by which Oban GPs operate the practices in Mull as a unitary practice. That is one example, at a GP level, of how we have effected change and how we have made substantial savings in regard to locums.

On recruitment, the island of Raasay, off Skye, proved to be a difficult area to recruit nursing staff to until, with collaboration from the local community, and as part of the north Skye redesign project, a significant effort was put in to attract

staff to that island. We had an astonishing response, with 30 applicants for the post, so we have good examples of ways in which we are attracting staff and also containing costs.

The Acting Convener: I see that John Connaghan wants to come in.

John Connaghan: I will be brief, convener—I do not want to extend your time—because Boyd Robertson has covered most of what I was going to say. I will just put the point to the committee that we are fishing in an international pool for specialists and consultants. Over the past five years, we have seen an increase of about 21.5 per cent in head count; that means that 35 or so additional consultant-level posts have been filled in Highland, which is welcome.

It might also be useful to point out that we need to make it attractive for applicants to come to Highland, particularly consultants at a certain stage in their career. We have done that by, for example, designating Inverness as a regional cancer service. Also, although we do not have time to do this today, at some future point the committee might want to look at what we are doing in Highland around developing new patient pathways—this is a first in Scotland; it is almost a first in Europe—around procedures such as colon capsule endoscopy. Again, that attracts younger clinicians who want to make a name for themselves. We are trying to do things to make it attractive to come and work in Highland.

Last but not least, we have an arrangement that we want to pursue around things such as shared appointments with other boards and travelling physicians, who now hold clinics—for example, there is one at the Golden Jubilee hospital for orthopaedics—which avoids locum costs at source. Those are all points that might be good to look into more.

The Acting Convener: I have a question for John Connaghan, and then Pam Dudek and Professor Robertson can come in.

Neil Bibby quoted locum staff costs of £14.9 million in 2017-18, £15.6 million in 2018-19, and more than £18 million in 2019-20. How is that progress? I do not understand how that could be perceived or portrayed as progress.

John Connaghan: Sorry—is that a question for me?

The Acting Convener: Yes, Mr Connaghan. Do you think that that is progress?

John Connaghan: Nobody can say that that is progress in a monetary sense, but let us remember that Highland is growing its services as well. It is in the process of recruiting staff for its elective centre, because we want to bring those staff on early. It is in the process of not only replacing staff, but adding new staff. It might also be useful to understand and correlate that back to the vacancy rate and how much of the vacancy rate is driven by new positions that we are trying to fill in Highland, so—

The Acting Convener: Mr Connaghan, I agree, but I believe the health secretary when she says that she wants to bring down locum costs. If the health secretary says that she wants to bring down locum costs, I do not think that she would regard an increase over each of the past three years as progress. Do you accept that that is not progress and that more work needs to be done to bring down locum costs in NHS Highland?

John Connaghan: I cannot argue against that—I accept that, on a monetary basis, a rise from £14.9 million a couple of years ago to £18.1 million does not demonstrate progress—but I hope that I have given you some views about how we can support Highland to redress that figure.

The Acting Convener: Thank you. Do Pam Dudek and Professor Robertson accept that that is not progress and that more work needs to be done to make progress and not just talk about progress?

11:15

Pam Dudek: Yes, absolutely, and I will revisit the analysis.

The Acting Convener: Thank you.

Willie Coffey: I want to go back to service redesign. Alex Neil asked a number of questions that I will not cover again due to time. I recall Audit Scotland telling us that we urgently needed an achievable plan for service redesign. Is that in place? I do not need to know what is in the plan, but is it in place and is it being worked through?

The Acting Convener: Who wants to take that one? Pam Dudek?

Pam Dudek: Am I on?

The Acting Convener: You are. I apologise. We can hear you.

Pam Dudek: We have had to rethink which key aspects to take forward in the wake of our experience of Covid and because we will be in a continuing position. The redesign is within that context. The remobilisation plan that John Connaghan spoke about will be an interesting document for the committee to look at. There are redesign elements to our plans for every bit of our business—financial recovery, performance recovery and remobilisation.

Those things are connected and are moving forward. We have strong work streams that are progressing, and we will continue to build on them.

There are work streams that go across the community and into hospital and back again, and there are specific work streams in some specialties.

The Acting Convener: I apologise profusely to my colleague Neil Bibby. I believe that I cut him off when he had not completed his questions. Can we go back to Mr Bibby? After that, we will go back to Mr Coffey.

Neil Bibby: I have a follow-up question that leads on to delivery of services and how that relates to staffing. I have heard concerns from people I know on the Isle of Lewis. I know that Professor Robertson mentioned the Isle of Mull. There are concerns that there is new equipment in the hospital in Stornoway, but no staff to use it. That has resulted in patients—some of them cancer patients—having to take two and a half hour ferry journeys and others having to fly to and from Inverness.

Apart from the inconvenience and the physical demands and stress of having to travel such distances, the travel costs for patients, particularly from an island, would be huge. I am aware that you cannot have a hospital in every part of the Highlands, but you have one in Stornoway that has equipment that is apparently not being used. What do you intend to do about that situation to ensure that patients can be treated locally where that is possible? How much are you spending on travel costs from the Isle of Lewis to Raigmore hospital in Inverness, and how much of that is being spent on services that could be provided in Stornoway?

Pam Dudek: Boyd Robertson is keen to take that one.

Professor Robertson: The hospital in Stornoway is part of the Western Isles Health Board; it is not part of our health board. Our health board is extensive enough already without adding the Western Isles, although I originate from there myself. We cannot comment on the state of play in the hospital in Stornoway and the equipment there.

Neil Bibby: Okay; perhaps that is a question for the Scottish Government at another point. Thank you.

The Acting Convener: Does John Connaghan want to respond to that question from a Scottish Government perspective?

John Connaghan: I would like a little time to look at the matter. I am happy to drop a note to the committee after we do some investigation, which will not take too long.

The Acting Convener: Back to you, Mr Bibby.

Neil Bibby: I have asked all my questions; thank you, convener.

The Acting Convener: I apologise to Mr Coffey for having to interrupt him and go back to Neil Bibby.

Willie Coffey: Thanks again, convener. I was having a chat about service redesign, and Pam Dudek was assuring us that the plan is in place, so, in the interests of time, I will leave that issue.

Earlier in the session, we mentioned increasing the number of digital consultations, which must be really important in an area such as NHS Highland's. One of the surprises that has come out of the Covid situation is the number of digital solutions that have been appearing: this session is one of them. Do Professor Robertson or Pam Dudek see more digital consultations happening? Will they continue beyond the Covid pandemic emergency?

Pam Dudek: The short answer is that that absolutely should become part of how we do our business. We have had an interesting experience. As Mr Coffey said, because of the rural nature of the board, NHS Highland was already fairly au fait with the use of digital solutions, such as NHS Near Me.

However, during Covid, we have learned that it is about giving people choice. Some of our patients are not able to use Near Me, because they do not have the technology, or do not believe that they would have the confidence to use it, even if they did. We are learning that a proportion of triage can still safely be done by phone, which for some people is a more convenient way to have their consultation, even when Near Me is available.

There are specialities for which Near Me makes a lot of sense for early-days consultations. Each area is currently reviewing its experience through Covid and is, as part of remobilisation, trying to understand the split between telephone, Near Me and face-to-face consultation. We are in the middle of that journey of understanding.

The next question will be how far we can take Near Me and how far it will help us. We have to look at it not only in a healthcare delivery context, but from welfare and economic perspectives, because for people who live in remote places, having to travel for a face-to-face appointment is inconvenient and might lose them a day's work. We are trying to think holistically about how we can apply the solution to help our population in their healthcare, and we recognise the associated welfare components and the wider economic and poverty agenda.

As we go through the next month or so, we will have a better understanding of that. We will also

look at the technical capability that we will require if we need to substantially step up Near Me. It is an important component and has real potential.

Willie Coffey: Thank you for that thorough response. Back to you, convener.

The Acting Convener: I will now go to Edward Mountain, who has joined us for the meeting today.

Edward Mountain (Highlands and Islands) (Con): I think that I am using up my lives by attending the committee twice in two weeks; thank you for allowing me to do that.

I will ask John Connaghan for clarification on a couple of points that he has made. You mentioned performance against the cancer treatment standards. Is that based on the same number of people presenting at doctors' surgeries as would normally be the case, or only on the people who turned up? My understanding is that people are not going to their doctors and seeking treatment, and therefore cannot be diagnosed.

John Connaghan: That is a good question. I will need to take a look at the historical activity. I will be able to do that only on the basis of published statistics—I cannot do it with unverified unpublished stats, at this stage. If you allow me a bit of time, I will give you the activity data. It would probably be best if I gave you the data by cancer pathway, rather than lumping it all together, so that you can see whether there is any change in relation to neurological cancers, head and neck cancers, breast cancer, lung cancer and so on. I can certainly dig that information out for you. Given that the numbers will be relatively small, it would be best if I were to provide the data over a time series, so that you can see the impact of time on the figures. A three-year period might suffice.

Edward Mountain: You also mentioned the elective care centre. Can you remind me when that was going to be built and when it will now be built? Staff are being recruited for the centre now. Can you explain that to me?

John Connaghan: I am sorry. What was the second part of your question? Was it about why staff are being recruited?

Edward Mountain: I would like to know when the centre was meant to be delivered and when it will be delivered, and when staff recruitment will be undertaken.

John Connaghan: Pam Dudek can talk to you about staff recruitment; she will have more information on that.

Construction of the new unit was due to begin in 2019. Advance works started on 20 July 2020, so as far as I have been informed there is at least a year's delay in the project from the original time plan. There are a couple of reasons for that. First, there was a change in the thinking about the centre. The initial design included space in the building for the University of the Highlands and Islands and Highlands and Islands Enterprise—

Edward Mountain: I am sorry to interrupt you, John, but I am happy just to leave those as bald facts. I know the reasons why the design changed, and I am sure that they are not of huge interest to the committee. I am interested in the fact that the centre will not be delivered until the latter part of next year, yet we are talking about recruiting staff for it now.

I welcome Pam Dudek to the committee—it is a great excitement for me to have a chance to talk to the fourth chief executive of NHS Highland in the four years for which I have been an MSP. I hope that there will be more stability in the future. If you could help me on the point about recruitment, that would be useful.

Pam Dudek: Thank you. I hope to be in post for some time and to serve the population well.

On recruitment for the new elective care centre, there are a couple of things to consider. First, we should look at how it will affect our overall staffing as it sits, and at who is and is not going to be part of the centre. We need to look at our existing workforce and how staffing for the new centre fits with it.

I understand that recruitment is starting on a phased basis to support the training activity that is required to ensure that the centre is good to go. Again, it would probably be worth the committee's while for me to provide a greater breakdown of what phase 1 looks like.

That is the approach that we are taking, and we have started that work. I know that that does not give you—[*Inaudible*.]—but I can get that information for you.

Edward Mountain: Okay. I will go back to the financial position.

I am impressed by Pam Dudek's statement that she is looking forward to the challenge. Here is the challenge, as I see it. In 2017-18, there was a loss of £17.8 million; in 2018-18, there was a loss of £18 million; and in 2019-20, there was a loss of £11 million. According to board papers, in August the projected loss was £75 million, £56 million of which will be down to Covid and £19 million of which will be down to normal losses.

How are you going to prevent a situation in which all of us are sat here next year—I do not know for how many years this has already been running—looking at NHS Highland and its financial problems?

11:30

Pam Dudek: We have a really strong understanding of where we are, financially. As I said, we have weekly surveillance of our financial position. In itself, that ability to have everything on tap, as we have, is a very transparent and helpful thing for a chief executive.

Covid is an issue across all the boards. Clearly, we are working with other boards and with the Scottish Government on the means by which we will deal with that.

I will take a step back from that and look at our core funding and trajectory. Again, I say that I believe that we are taking every possible action to address the core funding gap. At this point in the year, we have £11.7 million risk adjusted that we are absolutely on track to deliver as part of our recovery programme, and we have £18 million in the pipeline of opportunity. That leaves £6 million that we need to address. That is consistent with where we were this time last year, and is also in the wake of our having lost three months at the beginning of the financial year, during which we were focused on Covid.

I guess that that speaks to the capability that I have seen in the board through the PMO approach and through training and development, not just of the management team, but across the system. I therefore think that our action is to do more of that—obviously with sense checking and understanding of the on-going impact on services as we move towards a bottom line that we hope will, through those actions, be where it needs to be.

There are risks in that; I am not sitting here with a naive hat on. I believe that we are taking every possible action, including action with Highland Council on how mitigate the gap in adult social care. This month, we will have a joint monitoring committee meeting, followed very swiftly by a project board meeting that will focus specifically on adult social care and on the children side of the business, because they affect each other. Again, I am looking for a rigorous process on that, so that we prioritise together and optimise our opportunity to ensure that our budget gets back to where it needs to be.

Edward Mountain: It concerns me that you say that you are in the same place as you were last year, and that you are confident that you will get the figure down to £6 million this year. You not achieve that last year—it is only down to £11 million. That is a little unfair of me, as I know that that was the responsibility of your predecessor.

You talked about there being £18 million in "the pipeline of opportunity" of savings. I do not know what that means. What does that mean? What are you not going to do? For example, is it about gapping posts, reducing locums or not doing operations?

Pam Dudek: There is a whole suite of workstreams, which sits in the methodology of the PMO, in which ideas are generated and a value is placed on them. Those ideas then go through that rigorous five-step process to be deemed either unviable or viable.

The £11.7 million relates to those that have already been deemed viable and are in progress. Additional ideas are in progress or are being worked up, but they have not been signed off and we might not have confidence in them yet. We will still be examining the viability of others.

It is a very live process and it is being discussed with teams all the time. That certainly includes our locum costs—I am going to go back and have a real look at the analysis around those, on the back of this discussion—our nursing workforce, our adult social care services and vacancy control. Equally important is how our infrastructure plays out. We deliver all those services through a variety of things, such as the buildings that we use and our digital capability.

At the moment, we are just trying to understand how we can make those significant savings while protecting front-line services and trying to ensure that our quality of care is not compromised. That is not an easy task, but it is one that I will—[*Inaudible*.]

Edward Mountain: So shining the light down that "pipeline of opportunity"—to use your analogy—is not about cutting front-line services, gapping posts or reducing the workforce. Will you give me some particular ideas that you are looking at, so that I can understand that?

Pam Dudek: Our staff profile may well change. Some of the ideas might change the shape and the skills mix of the staff. That is a way of reducing costs, if it is reasonable and maintains quality. One big issue is how we deal with our out-patients. There is an out-patient workstream, and technology comes into that workstream. That is an example.

Edward Mountain: How much will that save you? Can you give a figure? Give me an idea of some of the figures in relation to the £18 million. I just want to get a grip.

Pam Dudek: I do not have a breakdown of the figures in front of me, but I would be very happy to follow up on that. I apologise for that, but I did not bring that level of detail with me, and I would not want to give members a figure that is misleading or incorrect.

Edward Mountain: I would like to ask a couple more questions, if I may, on operations. Even if you rebooted and got Raigmore hospital up and

running again, you would be approximately a third of the beds down, because there are not enough facilities as a result of the Covid restrictions. A lot fewer operations will be carried out. How will you ensure that people do not wait three years for a hip operation, for example, if that is the current waiting time?

Pam Dudek: That is the challenge that we have. Members will know that we are using clinical prioritisation as a method to work through our waiting times. A number of actions have been taken around the potential of mutual aid and some of the initiatives that we have managed to agree through the access collaborative with the Scottish Government. An endoscopy room has been brought on site. There are aspects of intervention that we have managed nationally to allow us to keep functioning. That is bringing us different spaces in which we can deliver some of our procedures. At the moment, we are also looking at our rural general hospitals and the concept—actually, it is not a concept, as we have already started with this; I mean that we are looking at how we can optimise those rural general hospitals, the space and the ability to do more procedures in them without the focus on Raigmore hospital. Our work with the PMO allows us to do deep examinations of what our capacity could be, providing that we can staff that and get in place the change that would allow us to increase procedures across our estate as opposed to simply focusing on Raigmore hospital.

Edward Mountain: I am sorry, but I am still at a complete loss. That went completely beyond me. I do not understand how the three-year wait that may be down the line for people who want hip operations will be reduced. There are a lot of ifs, maybes, mights and could happens. Surely if that is going to be done, you might have to outsource it, and that might cost.

Pam Dudek: I am sorry, but will you say that again? I am struggling to hear you.

Edward Mountain: If you cannot supply that in Raigmore hospital, you might have to outsource it. That would add cost, would it not?

Pam Dudek: We are looking at mutual aid with the other boards and how we might be able to do business with them, initiatives with the Scottish Government and what we can access in line with other boards, and getting access to external facilities that can assist us with some of our pathways. There is a challenge there, created by Covid, but we will continue to try and find every which way we can to address it.

Edward Mountain: My final question—

Pam Dudek: But I cannot give an answer on that at this point.

Edward Mountain: Okay. I come to my final question. Colin Beattie was absolutely on the button with the questions that he asked you at the beginning of this session. One was about Raigmore. In the Highlands, we have concentrated all the services into Raigmore, and we seem to be doing that more and more—whether that concerns Migdale hospital or Caithness general reducing their services, for example. Raigmore has become so big that there is no way of controlling the budget, yet you say that you have it under control. None of your predecessors had. Do you feel confident that you can control the costs of Raigmore, which has become so big that there is no localised control of budget?

Pam Dudek: At this stage, the budget is stable, and it seems to be in line. However, we are absolutely not looking at that without considering the potential risk, whether that is related to Covid or the actual level of pullback that has happened through our cost improvement plan. I have asked for scrutiny of that, which will help us better understand what the budget looks like going forward.

I do not believe that the budget is out of control, given our performance recovery work, by which I am referring to the system's performance stats, and given that we have agreed our remobilisation plan, which is based on a level of activity that is within the budget that we have at the moment. Anything else that we need to do is being decided on a fairly robust basis, and it is being considered within a cost envelope.

We are taking every action to control the budget and to optimise the level of service that we can deliver within the resources that we have available to us, with the safety that is required in the wake of Covid. As you say, that has some rate-limiting factors associated with it, which are of risk and of worry.

Edward Mountain: I am getting the "no more questions" sign from the convener, so perhaps we could continue this conversation offline.

The Acting Convener: It would make much sense, from a local perspective, if Mr Mountain and Pam Dudek could continue the conversation away from the committee.

I realise that this has been a long and extensive session for everyone. I give my sincere thanks to John Connaghan, Richard McCallum, Professor Boyd Robertson and Pam Dudek for your patience and engagement this morning, and I wish you and your teams all the very best.

11:42

Meeting continued in private until 12:08.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba