The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 22 April 2014

Session 4

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HEALTH AND SPORT COMMITTEE
12th Meeting 2014, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jackson Carlaw (West Scotland) (Con) (Committee Substitute)
Kathryn Fergusson (Scottish Government)
Paul Gray (NHS Scotland)
Professor Jason Leitch (Scottish Government)
Alex Neil (Cabinet Secretary for Health and Wellbeing)
Ian Ross (NHS Lanarkshire)
Dr Iain Wallace (NHS Lanarkshire)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 5

Scottish Parliament

Health and Sport Committee

Tuesday 22 April 2014

[The Convener *opened the meeting at 09:45*]

NHS Lanarkshire Mortality Rates

The Convener (Duncan McNeil): Good morning, and welcome to the 12th meeting in 2014 of the Health and Sport Committee. I have apologies from Nanette Milne. I welcome Jackson Carlaw from the Conservative Party as a substitute for her.

As usual, I ask everyone in the room to switch off mobile phones, BlackBerrys and other wireless devices, as they can interfere with the committee's business and the sound system. That said, I ask people to note that members and officials are using tablet devices instead of hard copies of their papers.

The first item on our agenda is mortality rates at NHS Lanarkshire. Members will recall that, following the discovery of higher than average mortality rates in acute hospitals in Lanarkshire last summer, the Cabinet Secretary for Health and Wellbeing set up a rapid review, which was conducted by Healthcare Improvement Scotland. The review was completed before Christmas and led to an improvement plan, with progress due to be reported to the cabinet secretary by the end of March. Today, we will hear more about that from NHS Lanarkshire and the cabinet secretary.

I welcome our first panel. Ian Ross is chief executive of NHS Lanarkshire and Dr Iain Wallace is medical director of NHS Lanarkshire. Thank you for your attendance this morning.

I invite Ian Ross to give a short opening statement before we proceed to questions.

Ian Ross (NHS Lanarkshire): Good morning, and thank you for the opportunity to discuss the Healthcare Improvement Scotland rapid review of NHS Lanarkshire along with the work that has taken place over the past few months.

The rapid review of NHS Lanarkshire's acute adult patient services identified areas in which there had been failings and unacceptable practice. There is no doubt that we regret that we did not always meet the highest standards of care that we want for our patients. We are also aware that United Kingdom and international evidence shows that up to 25 per cent of patients experience a safety incident while in hospital. We do not believe that that is acceptable for our patients.

We have provided the committee with a copy of the report that we submitted to the Scottish Government at the end of March. That report identifies actions and progress that we have made since the publication of the review in December last year. We have worked closely with Scottish Government officials and the governance and improvement support team as we have made progress against the review's recommendations.

The report demonstrates not only that we are making significant progress against the 21 recommendations; it clearly sets out the commencement of a journey that will lead to a transformational improvement in the provision of safe, person-centred and effective care for our patients in Lanarkshire. We want our patients to be confident that they receive that every time they access our services.

The review concentrated on only part of the service that our three acute district general hospitals provide, but the improvement work that we have been undertaking will be implemented across all services that NHS Lanarkshire provides, including primary care and mental health services. The improvement work has not been limited to the 21 recommendations; it has also addressed a range of issues that were identified in the report.

There has been significant progress over the past few months, but our work is not yet complete. As I have said, we are on a journey of quality improvement, and we have much more work to do, such as finalising and embedding simple and effective governance arrangements. We have achieved a solid baseline for our quality strategy, which we will implement over the next three years.

Significant changes have been and continue to be made. For example, we are investing over £5 million in nurse staffing. A £2 million investment was agreed prior to the review, and a further £3.1 million has been agreed since the review. The nurses from that investment should all be in post within the next few months.

We have put a focus on patient safety. In addition to recently appointing a new experienced patient safety lead, we are investing further in five patient safety staff to embed the Scottish patient safety programme across the organisation.

A review of consultant medical staffing is under way and we expect to further invest in consultant medical staff.

Extensive development of staff and patient engagement has taken place. Staff engagement has involved board, executive and site management staff, and for patients and members of the public we have built on and expanded on existing methodologies for gathering their experience and feedback to ensure that our

services are patient centred and to identify where improvements can be made.

We have simplified management structures and improved our operational effectiveness. Although the new structures have been in place only since 1 April, the changes have been welcomed and supported by staff. We will bed in the leadership teams to ensure their continued leadership development.

Overall, in such a short period we consider that we have made significant progress, which has been achieved through effective leadership at all levels in the board. The work that we have undertaken will ensure that we continue our journey with our aim to be the safest health and care system in Scotland, in which patients will have a positive and enhanced experience when they receive care in Lanarkshire.

Dr Wallace and I will be happy to answer any questions that you have about the review and to outline our progress to date.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I want to take us back to see where we came from and where we have got to. I appreciate that there is the new 55-page report. I do not know whether it has 21 recommendations, but there seems to be a very large number of action points, which are welcome, if they can be implemented.

The first report of a raised hospital standardised mortality ratio—the committee appreciates that that is only a smoke alarm and an indication that one needs to look at the problem—was for the period July to September 2011. Leaving aside the current report, I think that there have been three action plans since then. It concerns me that we went through a process in which HIS got involved by writing to you on 9 February 2012, when it said that Monklands was above the level and asked you to comment. You came back in March with seven action points. HIS came back to you and you modified your action plan again, and then the data actually got worse. Over the next 15 months, Wishaw and Hairmyres joined Monklands above the average.

Over 15 months and three reports—I do not know whether they were by the current leadership, but they were published under the structures prior to April this year—all those things supposedly happened, yet things got worse. Can we have confidence in the current plan and can you explain why the previous plans singularly failed to make a difference? What was going on then that the board or the senior executives were not aware of that resulted in the cabinet secretary having to be informed and having to set up the rapid review, which is beyond the normal process of HIS monitoring things and having discussions with you?

Ian Ross: We were working closely with HIS throughout that period, as you pointed out, identifying actions. Those actions were being implemented, but we were not making good enough pace. With the latest figures, we have seen Wishaw improve by 17 per cent, Hairmyres improve by 11 per cent and Monklands improve by 8 per cent, compared with the national average of around 12 per cent. We were not making good progress, but that has started to change. The actions put in place prior to and since the review are starting to drive that improvement. The formula that is used is complicated, but we take the smoke signals very seriously. We have taken actions and we have seen improvement over the past 12 to 15 months.

Dr Simpson: One of the things that you have to look at is how robust the data is. There was a 23,000 backlog in coding, which is supposed to be one of the factors that have affected the results from Lanarkshire, yet when the rapid review report occurred there was still a big backlog a year or 15 months later. Why was action not taken, at least to get your data right and to check whether the smoke signal was sending real smoke or false smoke?

Ian Ross: We were checking a number of areas. It is a formula that has an impact on a range of issues in hospitals, and data was one of them that perhaps we did not concentrate on early enough, although we have reduced that backlog over the past six months. We have also looked at improving the coding within six weeks of discharge from hospital, and full discharge letters have improved as well. We have recognised that, but we were concentrating on a range of factors to try to bring the HSMR figure down.

Dr Iain Wallace (NHS Lanarkshire): I came into post fairly recently, so I cannot talk about the past other than to say that the focus was on safety, on doing the early warning scoring systems—the sepsis six bundle, as it is called—and on using them to detect deteriorating patients. It was more about the clinical aspects than the coding. The criticism might have been that we were spending too much time focusing on getting the coding right, which other reviews show was a criticism of the board at the time. However, we are now moving forward, and the work that we have been doing on patient safety has led to a significant improvement in HSMRs in the last quarter for which figures have been published, which was prior to the visit of HIS in October.

Dr Simpson: I appreciate that Dr Wallace has only just come into post, but the timeline reviews state that one of the problems—apart from the lack of robust data, which we have discussed—was that Lanarkshire was concentrating on longer-term strategic items and not on the sepsis six

bundle. I would therefore contradict what you are saying, Dr Wallace. The report from HIS indicated that there was not a concentration on the things that really mattered. I am raising those issues only because other boards have to learn the lessons from Lanarkshire. Indeed, the Scottish health service has to learn those lessons. It is about focusing on the particular issues of patient safety and the sepsis six bundle, among other things.

Richard Lyle (Central Scotland) (SNP): As a local MSP in Central Scotland, I record the fact that Lanarkshire NHS Board is in my region. I compliment all the staff who work in Lanarkshire's hospitals and in the national health service to ensure that the rapid review and the report's recommendations will be fully implemented. However, as a Central Scotland MSP, I have to ask Mr Ross and Dr Wallace what went wrong and why it went wrong. The review made 21 recommendations and you now have an action plan with 100 action points. You have suggested that standardised hospital mortality ratios are falling and the situation is getting better. Lanarkshire NHS Board also has the highest number of nurses now. What steps are you taking to ensure that all the points are being actioned? As has been asked previously, are you sharing that information with other NHS boards in Scotland?

Ian Ross: As I said in response to the earlier question, we were seeing improvement but not the speed of improvement that we wanted to achieve. We recognised that there was a lot of work to do and we have tried to concentrate on those areas. It was done over a long period, and it takes time for the reduction in HSMR figures to occur. As Dr Wallace said, we have seen a significant improvement in those figures for all three hospitals in the past quarter. The main issue in bringing about that improvement was speed.

What was the second part of your question, Mr Lyle?

Richard Lyle: What action are you now taking, and are you sharing what you have discovered and what you have learned in the past months with other NHS boards?

10:00

Ian Ross: We are taking a great deal of action, and we are reporting that action internally to NHS Lanarkshire and sharing it with the Scottish Government. I have presented twice to chief executives and Scottish Government officials. We meet monthly and, at two of the three meetings that have taken place so far, I have presented and shared some of the learning. We have certainly had discussions with chief executives regarding some of the findings and what we have learned about how to put right some of the findings. I am sure that those lessons will be taken away by my colleagues to feed into their own health board arrangements.

Dr Wallace: Similarly, medical and nurse directors have had national discussions. All colleagues see great value in looking at what has happened elsewhere. A similar issue to do with adverse events came up in NHS Ayrshire and Arran a few years ago. Healthcare Improvement Scotland is sponsoring an event in May involving nurse and medical directors and chiefs of pharmacy to go through the report in detail, and Rosemary Lyness and I will have an opportunity to present the learning and the actions that we have taken then.

To go back to your first point, the report highlighted four or five key areas. The patient and care experience was great in parts and poor in parts, and it is a great disappointment to us that our patients do not have the best experience. Even if the technical care has been good, some patients do not feel that it has been person centred. We have taken a strong approach to getting patient feedback, whether it be through the kiosks at the front door at Monklands that we have been experimenting with or through cards that patients and carers can fill in when they leave the hospital.

The criticism has also been made that we should not do these things in real time because, when people are in hospital, they might not necessarily tell us all the things that they might tell us after they have left. We are therefore looking at how we collate that, but we are working within a short enough timescale so that people do not forget. If we leave it too long, people do not necessarily remember.

The workforce was another issue, and I am sure that we will come on to talk about that in detail later.

The Scottish patient safety programme was the third strand, and there was a big issue to do with operational effectiveness. In the past, the board had tried to bring together three trusts that all had their own cultures. It was managed on the basis of a horizontal structure, almost as if there was one hospital with three sites. Latterly, with unscheduled care and the four-hour standard for accident and emergency services being required to be managed on a site, there was a move towards more site-based management, but the HIS review was really the catalyst for that change.

Richard Lyle: I know the hospitals that we are talking about very well, and Mr Ross knows why I know them so very well; we have discussed it over the years. As I say, the staff in each of those hospitals are excellent. I have to record that a

member of my family will be using your services shortly, and the staff who I have met in Wishaw in the past couple of weeks have been excellent.

What action are you taking to ensure that all this is permeating down to the staff, and how are you getting staff on board with implementing the recommendations?

Ian Ross: The staff were very disappointed in the report, and those who deal regularly with patients and visitors felt that the public and patients had lost confidence in them. The staff have definitely shown their commitment to ensuring that the work that we have described in the report is fully implemented, and they have decided that they want to build patient confidence back up. We want to rebuild public confidence, whether through the media or in person.

We have tried to ensure effective communication with staff through the board going out visiting departments. We have increased patient safety walk-rounds, so that executive and non-executive directors can see some of the issues at first hand. We have established staff forums where managers hold meetings on community and hospital sites, and staff can come along and raise any issue that they want to raise. We have had human resources forums at which staff can raise issues.

We have increased the visibility of executives, non-executives and senior managers across all the sites in Lanarkshire, not just the three hospitals, because it is important that we get across the message that this is not just about the three acute sites but about NHS Lanarkshire itself. I think that we are also the first board to establish a website, called uMatter, where people can confidentially register any problems that they might have and which will be picked up confidentially.

For some time now, we have had other policies in place for staff who want to raise any confidential issues, but it is a matter of going out and building up a relationship between all staff. That will then go back to the patient, who will have a better experience. As a result, we will be able to build greater public and staff confidence in the services that we provide.

Richard Lyle: At a recent meeting with Central Scotland MSPs, did you not give a commitment to work more closely with MSPs on any complaints about NHS Lanarkshire that were raised with them?

Ian Ross: Absolutely. As you know, we meet all MSPs and, indeed, MPs, all of whom are invited to the meeting that we hold twice a year at which we highlight issues that we want to inform them of and to debate with them. Of course, I also speak to MPs and MSPs at other times, but at those meetings we give them the opportunity to add issues or concerns to the agenda. I should add that the meetings involve not just me but my senior team, and senior managers across NHS Lanarkshire also have regular dealings with MPs and MSPs on issues that their constituents have raised.

I believe that we are due to meet MPs and MSPs again at the beginning of May, and we want to hear whether they feel that there is anything else that we can improve on. At the last meeting, we touched on whether the format of the meeting itself should be changed; I think that one MSP suggested that we stop having them, but the majority wanted them to continue because they felt that they benefited from them. As a result, we will continue to have them.

Dr Wallace: In that respect, I should also highlight the new hospital structure, in which accountability lies with the hospital director, supported by the chiefs of nursing and medicine. As a result of that, MSPs will, in working with their local constituents, know that they can go to one person. Moreover, staff will see a clear line of accountability through the structure. Given that the new hospital structure does not have that many layers, any concerns can be escalated, and people will know where the office they need to go to is. In the previous horizontal structure, the director was not necessarily on the hospital site all the time.

The Convener: You have said that, since 2011, we have been involved in the discussions that you and many others right across the board have been having. Is it correct that this rapid review will conclude three years from now in 2017?

Dr Wallace: There are a number of actions that will go on for quite some time—

The Convener: We will come to that, but this journey began in 2011—

Dr Wallace: It is a quality improvement journey.

The Convener: And it will conclude in 2017.

Dr Wallace: I hope that most of the actions will have been concluded well before then.

The Convener: You think that you have given yourselves enough time, given that the process will conclude in 2017.

Dr Wallace: With any process of change in a big and complex organisation, things need to be embedded over a period of time. Indeed, one of the criticisms in the HIS report was that we were trying to do too much too quickly, and it will be important to embed these things. Some significant changes have already been made; indeed, as Ian Ross pointed out, work was already in progress prior to the review. The 2017 date relates to the

quality strategy, for which we have set a three-year timeframe.

The Convener: And that is the strategy that began in 2011. You are prepared to accept the criticism that although the process did not fail, it was slow in achieving its targets. However, Dr Wallace has just told us, "We tried to do too much."

Ian Ross: We want to stress that the health service is a complex organisation that involves a lot of people and a lot of work. Things need to be improved constantly. Even in 2017, we will not get there; we need to look continually at how we can improve our services, whether through new techniques or technology or as a result of more information coming through. The industry in which we work needs to improve constantly.

The Convener: You are speaking to the Health and Sport Committee of the Scottish Parliament. We do not work in the health service—although some of us used to—but we spend a lot of time hearing about the complexities of the service and how difficult things are.

On the publication of the mortality rates and the cabinet secretary's announcement of a rapid review, you were able to come up with more than 100 action points and 21 recommendations. You have all willingly accepted those recommendations and, indeed, you told us at the start of the meeting that you have added some of your own. So, why could you not have applied that sort of ambition and drive before? Who is responsible for that lack of ambition and drive prior to the review? Who has accepted responsibility for that failure?

Ian Ross: We want to stress that work was going on. It is not as though work just started after the rapid review; it has been going on constantly to try to make improvements. What the rapid review indicated was that we were not making progress quickly enough. I have said already that the national improvement was 12 per cent and we have 8 per cent improvement at Monklands; 11 per cent at Hairmyres; and 17 per cent at Wishaw. Improvement was just not happening quickly enough. We have now concentrated on actions to improve more quickly.

As Dr Wallace said, we have to watch that we do not just take surface actions that do not embed themselves into the culture and work patterns of staff. It takes time.

All of us in NHS Lanarkshire regret the fact that we did not make progress quickly enough and that we perhaps lost the confidence of some of our patients and some of our public. We absolutely regret that as a board.

The Convener: I am just trying to establish who has accepted responsibility for the failings that have gone on one way or another. A lot of the senior people are still there. There has been a focus on corporate governance. How can we be assured that the people who were in senior positions have changed their mindset and will address all the issues that have been identified in the review? The record up to now is not great.

Ian Ross: We consider that we were making progress. I know that I keep coming back to that point, but we were making progress.

The Convener: Are you suggesting that the review was unnecessary?

Ian Ross: No. We accept that the rapid review looked at some of our services and found that improvements needed to be made.

I emphasise that it applied to a small part of the three acute hospitals' work. NHS Lanarkshire was excellent in other areas. If you look at our treatment time guarantee performance, our cancer waiting times and our financial performance, you will see a very good record. We were performing well in a number of areas; we were not performing as well in that area.

The Convener: It would matter to the population that 50 per cent of the action points are about patient safety.

Ian Ross: Patient safety is something that we will work at for the next three or four years. We need constantly to improve and look at our services and we and other systems will do that. It does not matter that it will all be embedded perhaps within the next 12 months or two years—it will go on beyond that. We in the health service need to look at such matters constantly.

The Convener: Dr Wallace is a new appointment. Has there been any review of the management team that presided over that period? Do any of them accept any responsibility for the slowness of progress?

Ian Ross: We all accept responsibility.

The Convener: But you are all still there. There have been no major changes, other than the appointment of Dr Wallace.

Ian Ross: Dr Wallace has started. I started nine months before the review. A new nursing director has started within the two and a half or three years, I think.

Dr Wallace: Obviously there is work to be done on the safety programme and there is a lot of impetus behind that. However, at the time of the review, the HIS report stated:

"The national Scottish Patient Safety Programme team advised that NHS Lanarkshire's existing level of improvement is in line with other NHS boards".

Therefore, we are all on that journey at the moment. I was at NHS Forth Valley before and we were on the same journey there. There is definitely work to be done and I am looking forward rather than back.

10:15

The Convener: You will understand that it is very difficult for the committee to review the situation when the people who can come along at this point in time say, "Well, I wasn't there, so it was really nothing to do with me." That is not great.

Bob Doris (Glasgow) (SNP): My colleague Richard Lyle mentioned that the Lanarkshire board is in his region; I should put on record the fact that some of my constituents—in Rutherglen and Cambuslang—will now be serviced by NHS Lanarkshire because of the boundary changes for NHS boards. I also apologise that I will have to go out of the meeting as I have to deal with some other matters this morning.

The convener is quite right about the committee's frustration in trying to scrutinise what improvements are being made, but I am going to look forward rather than look back. I understand why some of my colleagues want to look back and scrutinise what happened as well.

Can the panel perhaps give me two or three benchmarks that the committee will be able to return to? Can you put on the public record today a particular thing that you expect to have done by the end of the year, or the middle of next year—fact—and for which you will be held accountable if it has not been done?

Can you start to give us something tangible that we can grasp and scrutinise as we go forward? We can have a discussion about who was not showing leadership at a board level—I understand why some of us would want to have that conversation. However, what I want to know is how the committee in December this year or in the summer next year will be able to check that NHS Lanarkshire is performing well and delivering on its benchmarks. It is about speaking not just in general terms, but about specifics—can I perhaps get some things that we can look at?

Ian Ross: On listening to patients and getting their opinions, we are adopting a blended approach. We have talked about the listening booth in hospitals. We have also signed up to the patient opinion website, and if you go on that website you will see the issues that have been raised, which have been mainly positive.

We will have a new policy on how we inform patients and receive information from patients—that will go to our board in June. Already we have seen investment in nursing staff—in March, we identified £3.1 million for investment in additional nursing staff, which was on top of the £2 million previously identified before the rapid review.

We have changed the management structures already; we have moved away from the complex site-crossing arrangements to focus much more on single-site arrangements so that people have a clearer line of accountability and a clearer perspective on how to raise issues and how to identify issues on the site. When I say "people" I mean the public as well as staff.

Those are some of the areas that we are looking at.

Dr Wallace: We put quite a range of measures in our March update on the HIS action plan to the Scottish Government, which was circulated, and quite a number of those measures are about patient safety. For example, we are aiming for 95 per cent reliability in the modified early warning score in accident and emergency and emergency receiving areas by December 2014. At the moment, we are about 80 to 90 per cent reliable.

Bob Doris: Dr Wallace, before my eyes glaze over as we get into technical speak, for my benefit can you keep the language punter friendly? You are talking about listening to patient opinion. Can you tell me what the mechanism will be? How will you pick up more effectively than you were previously whether patients are unhappy? What will happen? If you have a cluster of five or six patient concerns in one of your hospitals, how quickly will that be identified? What is the turnaround? What actions will be taken?

Listening to patients is fantastic and we should do that, but we also need to act on patient concerns. Can you give me a flavour of what that will look like?

Dr Wallace: Just on complaints, because we now have a single-site arrangement, the director, the nurse and the chief doctor will be seeing the complaints as they come in. Again, this is a bit of jargon but we look at the risks in relation to complaints. Some complaints are about car parking, for example, which is clearly important, but if there is a clinical complaint, the chief medical person will be right in the middle of that from the word go.

We track trends and every month, five patients in every ward are sampled. We increased that to 10 at Monklands. That information will be fed back to the hospital management teams.

Bob Doris: I expect hospitals to strive to be perfect but I do not expect any of them to be perfect. It would be quite helpful if, when you identify a cluster of complaints, you show what

action has been taken and inform this committee. That would be worth while.

Dr Wallace: We can arrange for that. Ian Ross and I, along with Rosemary Lyness, take a random sample of complaints from each hospital, sit down with the team and look through the responses. Was the response what we would call person centred? Does it answer the questions and address the anxieties that have been expressed? Is there learning across the board and not just in that department or ward? We do that monthly now, and it has been an interesting experience. We do not get it right every time and we are looking for improvements.

Bob Doris: That would be helpful.

You mentioned an additional £3.1 million investment in nurses. The committee has scrutinised the issue of nurses in detail. There may be many more nurses, but the issue is what those nurses are doing. Can you tell me about the additional nursing investment and about the workload and workforce management tools that are used to deploy those nurses? There must be a focus for what those nurses are doing. Politicians like to say, "We have more nurses," and we all cheer, but we want know what that additional investment is for and what specifically is being prioritised.

Ian Ross: Before the review, we invested some £800,000 specifically to give the ward sister—the senior charge nurse on the ward—free time to focus on care for patients and how the nursing staff were providing care. We took them out for three days a week. They were not part of the clinical team, providing care, but they were still based on the ward and they could look at how improvements could be made and how the staff were caring for patients. We called it supervisory time. We invested in more nursing staff at the bedside and gave ward sisters time to supervise the arrangements in their wards. That was one specific area.

Dr Wallace: Altogether from that investment there were about 150 additional whole-time equivalent nurses. Between a validated tool for nursing—the Keith Hurst tool—and senior professional judgment, areas were decided into which to put those nursing staff. They are front-line nursing staff and not nurse managers or people who do administration. This is about having clinicians on the front line.

Rhoda Grant (Highlands and Islands) (Lab): I want to go back slightly to the pace of progress. Why was progress not fast enough?

Ian Ross: As I said, improving mortality ratios is part of our work in NHS Lanarkshire. We are doing lots of other work on the services that we provide, including on treatment time guarantees and whether those comply with the legislation and patients receive their treatment on time. We have been looking at the development of cancer services and waiting times for those services. We invest in community health services and mental health services—we have made changes to mental health services in Lanarkshire.

We need to concentrate on and improve the pace of change. We tackle a varied and wide agenda in the health service, and this work is part of that.

Rhoda Grant: Are you saying that that would have been the speed of progress anyway, or were mistakes made in relation to the speed of progress? Should it have been given more priority, or was the issue not important?

Dr Wallace: Safety is the most important issue that we address. If we unpick the past, we see that the board's scheduled care performance has been excellent, but unscheduled care has been a challenge. Workforce issues have had an impact on that. The investment in additional nursing staff had begun before the HIS review took place, but there has now been enhanced investment. That is a way to make things happen more quickly.

On the challenges around medical staffing, the money is there, but the doctors are sometimes difficult to recruit. That is a UK-wide phenomenon. If we can get extra staff in, the pace of change will be even quicker than it currently is. We are making good progress.

Rhoda Grant: You recognise that the speed of change was not fast enough, but you are saying that that was down to problems with recruiting staff to fill the gaps.

Dr Wallace: Having the staff on the ground is an element of it but is by no means all of it. We have a new head of patient safety, so there is a new focus there. Jane Murkin, who may have given evidence to the Health and Sport Committee in the past, has led the patient safety programme since its inception five or six years ago. Getting fresh eyes on the challenges that we face is helpful.

Rhoda Grant: There is something that I am struggling to get my head around. Serious concerns were raised in July 2011 about patient mortality rates and so on. Does it take three years to recruit? What was the stumbling block? Why was progress so slow, given the seriousness of the concerns?

Dr Wallace: We talk about the mortality ratio, HSMR—I will not go into great detail on that ratio unless you wish me to. Just to reassure you, the mortality rate—what we call the adjusted mortality rate—across the whole of NHS Lanarkshire is just slightly above the Scottish average. Quite a

number of boards have a higher rate than NHS Lanarkshire, so it is important to put the issue into perspective.

Ian Ross is probably better placed than I am to think back to 2011, but there is a constant dynamic in healthcare around where to deploy our staff. It is quite clear that we need to get more nursing staff through the front door. There is an increased number of admissions of over-85-year-olds with very complex patient care needs. Even over the past three or four years, things have changed quite dramatically, as can be seen with the pressure on our emergency departments.

Rhoda Grant: Surely every NHS board is facing those issues.

Dr Wallace: Yes.

Rhoda Grant: So, why was the position different in NHS Lanarkshire?

Dr Wallace: In a number of places, the report discusses providing services across three sites. Orthopaedics is mentioned in particular. We are looking to develop a clinical model that aligns with the workforce availability as well as with the needs of patients.

Rhoda Grant: So, the need to operate over the various sites was the problem.

Dr Wallace: That was just one factor; there are a range of factors.

Rhoda Grant: I am trying to pin this down but, every time I mention one thing, the discussion moves off somewhere else.

Dr Wallace: It is a factor, but it is not as easy as saying that the problem is one thing; there are issues in combination, including the availability of workforce, how the board's services are configured and the leadership at hospital level. All of those things together are important.

Rhoda Grant: I will turn the question round the other way. What could have changed or been in place to make the response faster? We need to learn lessons. If the same thing happens again, we do not want the same length of time to pass before we seek change.

Dr Wallace: There is a benefit to what I would call peer review—getting others to come in. There were 18 people on the team and they spent three whole days looking in every nook and cranny of the hospitals. Looking with an outsider's perspective is really helpful. If I had had my way, there would probably have been some sort of peer review with an improvement focus rather than a scrutiny focus and it might have been good to do that back in 2012.

HIS was involved with the board and was exploring a whole range of things at the time. Perhaps such a review might be helpful in the future. That goes back to what NHS Quality Improvement Scotland and the Clinical Standards Board for Scotland did four or five years ago, which was more of a peer-led review of services. That is what we are considering going forward, based on this, the first extensive review that has been undertaken in Scotland. There is a lot of learning.

Rhoda Grant: When did that happen?

Dr Wallace: Sorry?

Rhoda Grant: The peer review.

Dr Wallace: The review that I am talking about was the peer review, which was done in October 2013. However, we might have had a peer review prior to that that would have focused more on improvement than on scrutiny.

10:30

Aileen McLeod (South Scotland) (SNP): I want to pick up on some of the points around the updated action plan. Perhaps you can put on the record some of the areas in which you faced particular challenges in implementing the action points outlined in the action plan and outline specific areas in which improvements still require to be made.

Ian Ross: A lot of the overall challenge has been in getting staff to embrace the changes quickly. I think that they have grasped that, but the challenge is that there are 11,000 staff in Lanarkshire and we need to change the way in which we work sometimes. We need to increase the pace and embed the work that will improve patient safety. The challenge is to change the organisation around in that way. That is why it takes time—coming back to the issue of the dates—to embed the changes.

The rapid review looked at only a small part of our health services in Lanarkshire. However, we want to improve patient safety and the quality of all our services in NHS Lanarkshire. The challenge is not only to make the changes, but to get people and patients to accept what we are trying to do. We need staff to embrace the changes, accept responsibility for making them and train other staff—that is the biggest challenge.

Aileen McLeod: I also asked about what other work you think needs to be done to get the improvements in place.

Ian Ross: We must constantly look at the improvements that we have talked about, such as the early warning scores. Because we implemented that improvement, we are starting to see our cardiac arrest rates going down. We need to continue with such improvements, embed the

new management structures and improve our arrangements for listening to patients and reacting by doing something, whether sending letters, meeting patients or understanding how we can change our services. Therefore, we will be on a continuing journey for the next few years, like every health board in Scotland.

Jackson Carlaw (West Scotland) (Con): As a substitute member of the committee, albeit one who has been here before, I have not been following the ebb and flow of this issue, but I read a lot of the papers in advance of today's meeting. May I ask, as a businessman, whether you have a grip? Are you assuring us that you have a plan that, for all its complexities, is comprehensive and which you now believe will deliver the necessary results? Would patients and families using the hospitals in your health board area have reason to feel safe? When should they expect to see that you have delivered? I know that you have an outline date, but when do you believe that you will have delivered a health service that they will regard as second to none?

Ian Ross: I assure you and the committee that we have a grip. We have identified the work and are managing it and reporting it to Scottish Government officials. We also report it regularly to our board and our management team. There is a definite grip on delivery throughout the organisation, not just by Dr Wallace and me.

In the plan that we have worked through, we have identified milestones that we need to achieve. For example, we need to undertake patient safety walkabouts to identify whether the changes are being embedded and whether all the staff understand what they should be doing. We need to constantly look at that and improve on it.

When will patients feel the benefit? If an individual patient has a bad experience in six months' time, they might think that we have not improved at all. One of the changes that we have made is to take a full subscription to the Patient Opinion website, which allows patients to go online and record whether they have had good, bad or indifferent care in a health board area. Since we took the full subscription, in January, I would say that about 70 to 80 per cent of the comments posted on that website have been very good and supportive of the health services. However, we need to work at that constantly. We will never know whether everything is okay for patients. A patient may have a bad experience tomorrow—which we would regret—and they might not think that we have improved, although I think that we have.

Dr Wallace: There is a poster at the entrance to each ward that says who is in charge of it and who is in charge of the hospital. We hope that that reassures people and that they will know who to go to if things are not working out. We have explained in, I suppose, punters' terms what the patient safety programme is all about—rather than the highfalutin' stuff that I have come out with, which I am sorry about—which should also reassure patients and their relatives that we are on the case.

We have a good grip on things. Our action plan is comprehensive and we will have made some good progress by the end of the month. However, the journey is not at an end. In fact, it will see me through to retirement and beyond.

Jackson Carlaw: Punter language is important, as Dr Wallace and I ought to understand, both being sons of motor traders. [*Laughter*.]

The Convener: We all wish you well with the ambition, but what challenges have you identified that need to be overcome for you to get to that point and what discussions have you had with NHS Scotland—and the local politicians that we discussed earlier—about the barriers and challenges? You mentioned the recruitment of consultants in certain disciplines. Can the current configuration in Lanarkshire sustain things, or does it need to change?

Dr Wallace: The medical directors' biggest concern is around the medical workforce. The shortages do not affect just Lanarkshire, but we have smaller on-call rotas. The bigger a hospital is, the more people can share the out-of-hours burden, so we need to look at that. The adverse publicity that there has been might make someone think, "I'd rather not go there—I'll go somewhere else instead," particularly when there are shortages.

It is important to us that we build confidence, most importantly for patients and carers, but also for medical staff in the west of Scotland. Our trainees get good experience when they come out to Lanarkshire and many of them go on to become consultants. We just need to make the quality of their working lives in Lanarkshire all the better. I suppose that we need to get all-party support for looking at our services and how they will be configured in future, and we will be looking to do that.

The Convener: I think that I speak for a lot of people around the table when I say that, in recent discussions with the cabinet secretary, we have recognised that this is a difficult issue and that in some ways it should be above politics. You have an ambition and a plan to move on with reconfiguration. I speak as someone who comes not from Glasgow but from Inverclyde, and we have had similar problems with attracting and recruiting staff and having to share services. You have an extensive plan and action points; much of that represents good practice that should have

been taking place—I will say no more than that. How do we fundamentally change the position so that all the services can be delivered effectively and sustained over a period of time? The community wants services to be delivered as locally as possible.

Dr Wallace: On medical staffing, we are recruiting and we are working with the Scottish Government on various avenues to get into post additional doctors of middle grade as well as consultant grade. We are trying to move towards the seven-day service that we all aspire to. Weekend care should be as good—in emergency terms, anyway—as care during the week, but that requires more consultant presence on the weekends. We are probably going to look at at least an additional 12 consultants for acute and emergency medicine.

The Convener: Is that a long-term solution, rather than a reconfiguration of services?

Dr Wallace: I think that it is a blend of different things—the workforce and the reconfiguration.

The Convener: Yes. I think that your father was a politician rather than a motor dealer. [*Laughter*.] Again from an Inverclyde perspective, it is difficult to attract people. That is not a new problem. How do we overcome it?

Dr Wallace: For me, it is also about how we construct the jobs. If the rotas are more arduous, are there other things that can be provided? We are doing a lot on patient safety. There can be additional training and some protected time to look at patient safety initiatives in the consultant's area or quality improvement initiatives.

The Convener: Do three different rotas work over the hospitals?

Dr Wallace: The hospitals currently tend to have separate rotas.

The Convener: Will that mean that, even within Lanarkshire, there will be a more arduous on-call service at one hospital as opposed to another?

Dr Wallace: They are roughly the same size. We have some services that are based predominantly on one site. For example, vascular surgery is at Hairmyres, so all those patients would go there, as is the optimal reperfusion service, which involves putting in stents for coronary problems.

The Convener: Does the patient flow impact on the training and development of junior doctors? Is that an additional problem? What about the royal colleges? I know from my experience in Inverclyde that the levels and numbers of operations or practices impact on training and accreditation, which can be withdrawn. Is training and development in place in all the hospitals, or does it vary?

Dr Wallace: We provide training in all the hospitals. However, to take emergency medicine as an example, Wishaw does not have many middle-grade doctors in training in emergency medicine—most of that training is carried out in Monklands and Hairmyres. We are working with the postgraduate dean in the west of Scotland on the report and how it might impact on training. Quite rightly, middle-grade doctors are being trained to fill consultant vacancies, so we need to find other avenues to find other doctors to do the middle-grade rota if we do not have the trainees. They are specialty-grade doctors, but they are currently quite hard to find.

The Convener: How significant are those barriers in fulfilling your ambition for sustainable services? Can the services be sustained over the three sites?

Dr Wallace: Lanarkshire will have three hospitals; we need to start to have a debate about how the services are configured in the three hospitals.

The Convener: But not necessarily three accident and emergency departments.

Dr Wallace: I think that you would always want emergency care to be provided as close to patients—

The Convener: You are a politician, Dr Wallace. I think that we all agree that we face those challenges and we need to be as honest as we possibly can be about them. I think that I have received my answer.

Ian Ross: We are working with our consultant staff already and discussing how we configure services, how we will continue to provide services across the three sites, and how will that help recruitment and the sustainability of services. We are working very closely with them, and they recognise some of our difficulties in matching patients' requirements and needs to the available workforce. Over the next few months, we will require to work through with them how we will configure services.

The Convener: Those are significant challenges that are about delivering your ultimate ambition.

Ian Ross: Absolutely. There are significant challenges internally and externally with the political world and the public world. People perhaps think that, just because a doctor or a nurse is there, that is about the quality of services, but we know that that is not always so. We want to try to improve the quality, but it is sometimes difficult to get that message across fully to the public.

The Convener: Again, I am sorry to be parochial, but in Inverclyde, we have had the Royal colleges withdraw accreditation. Have you had any pressure there?

Dr Wallace: Not currently, fortunately.

The Convener: Not yet—not currently. [*Laughter*.] We are just back from a recess.

Richard Lyle: As a local MSP for Lanarkshire, I have to say that the people of Lanarkshire want the three hospitals and the three A and E departments to stay in the sites that they are on, but I will not go down that road.

Page 18 of your report covers in part that issue. The NHS provides hospital services 24/7 52 weeks a year or 53 weeks in a leap year. How do you ensure that consultants work at the weekend? You have said that weekends are just ordinary working days for people nowadays, which is unfortunate in some ways. However, many things happen at the weekend. How do you ensure that cover is provided? I see from the report what you are doing, but I am also interested—Mr Ross will laugh when I say this—in out-of-hours care, as I worked previously with such services. What is happening there? Do you have problems with staffing the various out-of-hours Lanarkshire sites with doctors?

10:45

Dr Wallace: Our aspiration is to have consultant physicians working until 10 or 11 pm seven days week in the hospital. We meet that in some of the sites, some of the time, which is why we are attempting to recruit about 12 additional whole-time equivalent consultants. That refers to emergency care.

We have accident and emergency consultants who sleep in the hospital to ensure that patients are safe. They do not provide a full shift on the floor, but they are on site, because a more junior doctor is on shift and we do not feel that it is right for the junior doctor to be left to manage patients without that consultant supervision.

It is work in progress. We are doing a risk assessment and the intention is to beef-up the front door medical establishment in that regard. However, the work also covers what we call the back door of the hospital, which includes the downstream wards. For example, you get flow through a hospital not just by focusing on the accident and emergency department; patients must be discharged home well to create space for those who are ill coming through. Having consultants available for ward rounds on Saturdays and Sundays in the downstream part of the hospitals is very important, too.

Richard Lyle: And the out-of-hours service?

Ian Ross: Mr Lyle is aware that we have three out-of-hours services based in each of the district general hospitals, which is one in each hospital, and two sub-general practitioner out-of-hours services, one of which is in Lanark and the other in Cumbernauld. As is the case with all health boards, it is proving more and more difficult to recruit and appoint GPs to out-of-hours services.

We have arrangements to recruit first to the three out-of-hours hospital services; if we can recruit fully, we provide services in both Lanark and Cumbernauld. However, it is becoming a challenge for us to do that. We are undertaking a review of the situation to see whether we can change the skill mix, such as whether nursing duties can be carried out by nurses rather than by doctors. Along with other boards, we face challenges in appointing GPs to out-of-hours services as we move away from the original GP contract.

Dr Simpson: Out-of-hours care is a whole different issue that we will probably have to come to. I will pick up on two matters, the first of which relates to what Richard Lyle has just mentioned and what Bob Doris talked about when he asked what progress we can get by December this year or summer next year.

I will suggest some things that, were we going into the hospitals and doing a peer review, we should see. For example, the modified early warning score system should be calculated each time basic observations are made, which is a prime recommendation of the report. Escalation should be clear, prompt and effective, and there should be a significant reduction in the time taken to deliver the sepsis six care bundle, which I mentioned earlier. It should be delivered within one hour of identification of sepsis, which can be a significant cause of mortality.

Richard Lyle's point is that we should never again read that a senior person has not added comments to a patient's notes for five days. Junior doctors are making significant decisions, often on deteriorating patients. With the general implementation of the hospital at home service, junior doctors are looking after not only the ward or division in which they are involved, but many different wards and divisions. Having only junior doctors doing that as part of the hospital at home service is a recipe for disaster, unless there is effective higher middle grade and consultant cover. In answer to Bob Doris's question, I think that those are the three things that, next year, the committee should be asking about with regard to review and implementation.

Finally, I heard in a report back from the e-health conference held across the road in Dynamic Earth the other day that Lanarkshire was very proud of its A and E dashboard, which meant

that its senior executives could phone a consultant if a breach of the four-hour target was going to occur. If that is true—and the claim was being made with some pride—I have to say that I regard senior executives phoning on a four-hour breach as the complete antithesis of patient safety and care. That is just tick-box stuff.

Ian Ross: I can say absolutely that that does not happen in NHS Lanarkshire. All A and E departments have a dashboard that shows performance; it is available to others, but it allows A and E departments to look at how long patients are waiting. It is absolutely not for executive directors to ring people up and say, "You must move this patient."

Dr Simpson: I am glad to have got that corrected.

Dr Wallace: I was actually looking at the dashboard last night, but I did not make any phone calls.

I absolutely agree with the other points that Dr Simpson has mentioned. Indeed, our patient safety strategy, which we are just about to conclude, covers those three areas and those measures will be made available to the committee to allow it to see how performance has improved from what was set out in our March report.

Finally, on patient notes, I should say that although my senior colleagues sometimes do not write those notes, that does not mean that they are not written at all. However, we are moving to a position in which the most senior person either writes the notes or at least notifies that they were present during the note taking, and we are carrying out an audit of notes for that very purpose.

Dr Simpson: Thank you.

The Convener: As members have no further questions, I give our witnesses the chance to put on record any specific issues that we might have missed in what has been a wide-ranging discussion.

Dr Wallace: Wherever I go in NHS Lanarkshire, I find the staff to be hugely well motivated and to be doing a difficult job in challenging circumstances. After a review such as that carried out by the HIS, you might have expected a bit of defensiveness and people turning inwards. However, I have seen the exact opposite; people are saying, "Let's get on and deal with the 21 recommendations in the report." As a relative newcomer, I have found that very refreshing.

Ian Ross: I not only echo Dr Wallace's comments but ask the committee to recognise that although the review and our response to it are part of our work in NHS Lanarkshire, a broad range of other work is going on. The review has shone a light on some areas where we need to improve, but I ask the committee to look at all of NHS Lanarkshire's other work, which is very good.

The Convener: I thank both witnesses for their attendance and evidence and suspend momentarily for a changeover.

10:53

Meeting suspended.

11:00

On resuming—

The Convener: We continue with agenda item 1, which is mortality rates at NHS Lanarkshire. We welcome Alex Neil, the Cabinet Secretary for Health and Wellbeing; Professor Jason Leitch, clinical director at the Scottish Government; Paul Gray, director general of health and social care and chief executive of NHS Scotland; and Kathryn Fergusson, head of medicines branch at the Scottish Government. I invite the cabinet secretary to make an opening statement before we move to questions.

The Cabinet Secretary for Health and Wellbeing (Alex Neil): Thank you for the opportunity to update the committee on the Healthcare Improvement Scotland review of services at NHS Lanarkshire. In addition to what Ian Ross and Iain Wallace said earlier, I would like to provide some details of the work that has already taken place and of the improvements that have been made in NHS Lanarkshire following work undertaken by the board since the HIS report. We last spoke on 4 February 2014, and I am pleased to report that I am satisfied that there has been substantial progress since then and that I am reassured by the energy, commitment and focus that have been shown by the board and by all the staff at NHS Lanarkshire to ensure that those changes are embraced and bedded in sustainably.

Patient and public confidence in NHS Lanarkshire is critical, and I believe that the action that has been taken since the HIS report and the work that is still to come will allow us to rebuild that confidence in high-quality, safe services. In a moment, I will outline my plans for ensuring that that remains the case. You have heard from Ian Ross, the chief executive, and from Iain Wallace, the director of medical services, and I am grateful to them for updating the committee on the progress that has been made to date. They both also set out the further work that is in train, and I am grateful to them for doing that. Some of the issues that were identified in the HIS report need longer than three months to embed organisational change completely, so there is more work to be

done on governance and accountability; the board acknowledges that, as I do.

The committee will be aware that, in August last year, I commissioned Healthcare Improvement Scotland to conduct a review of the quality and safety of care for adult acute patients in NHS Lanarkshire. That followed routine monitoring of hospital standardised mortality ratios through the Scottish patient safety programme, which indicated that, although there had been a fall in HSMR figures over the past five years in all three hospitals in Lanarkshire, Monklands hospital had not progressed sufficiently.

HIS provided me with the report and its findings in December and I then appointed a governance and improvement support team to engage with the board, providing challenge and support for its actions to address the recommendations that had been made by HIS. I thank the members of the GIS team—Jeane Freeman, chair of the Golden Jubilee national hospital; Malcolm Wright, chief executive of NHS Education for Scotland; and Professor Sir Lewis Ritchie, director of public health at NHS Grampian—for their significant hard work in assisting NHS Lanarkshire.

The HIS report made recommendations for improvement, and it was agreed that NHS Lanarkshire would provide weekly progress reports on action. More detailed monthly reports have also been provided. Many of the actions taken by the board have already been effective in addressing the concerns that were raised in the HIS report. For example, the board has reviewed its processes for collecting patient and carer experience data, to ensure that patients and carers feel able to provide honest feedback that reflects both positive and negative aspects of care and can be used to further improve care. It has rerun the workload tools with occupancy levels reflective of wards' actual activity, so the additional £3.1 million that the committee has heard about this morning is being invested in acute nursing services, leading to the appointment of an additional 150 or so full-time equivalent nurses, prioritised for the wards and units that have the most significant gaps against the assessed level of need.

The board is ensuring that a further review of nurse numbers and of the skill mix is addressed in conjunction with wider work on vacancies, bank use, rostering and admin support. It is also ensuring that there is a clear focus on embedding patient safety throughout the organisation, and the creation of a dedicated patient safety team led by an experienced head of patient safety is key to that. It is delivering swiftly on the simplification and strengthening of acute management structures, centred on the appointment of three new hospital directors, one for each site, along with a lead nurse and lead clinician for each site.

To ensure that we build on these successes, the board has reviewed its clinical governance structures, which will ensure clarity and transparency, and accountability for the safety and quality of care. That is welcome work in progress, and I have asked my officials to continue to work with the board to ensure that the new structure is clear and effective and builds the confidence of clinical staff through a strong engagement process.

I am assured that the board understands how critical it is that it receives and reviews reliable, timely and meaningful information regarding quality and safety, to enable it to perform its crucial leadership role, which involves support, challenge and accountability. I have asked my officials to continue to engage with the board on that important agenda.

To ensure that we take appropriate stock of the sustained nature of the progress, I confirm that follow-up meetings will be held with NHS Lanarkshire, the Scottish Government and the governance and improvement support team in June and September this year to review progress, and that the GIS team will continue to be available to provide the board with support whenever it may be needed. I also confirm that Paul Gray, director general of health and social care and chief executive of NHS Scotland, will meet the senior representatives of the three medical staff associations in Lanarkshire on 25 April. That provides another chance to hear at first hand the views and contributions of the local medical community on the changes that are being made, and to ensure that their on-going engagement and ideas for further improvement remain central to sustainable change in which everyone can have confidence.

The board of NHS Lanarkshire is fully behind the improvements and I wish to acknowledge its enthusiasm and commitment to respond positively to HIS's recommendations in the review report. I have been clear with the board—and publicly—that the problems identified in the HIS report were not acceptable and that rapid and sustained improvements were essential. I am pleased that the board, supported by all its staff, has taken responsibility and made a real step change in its focus on quality and safety of care as a result of the HIS report recommendations. I am confident that the improvements will be maintained, embedded and built upon where necessary.

However, as you would expect, I consider these issues sufficiently important that I will seek clear, on-going assurances that the improvements are sustained—personally, from the board, and

through the follow-up discussions between the board and my officials.

Thank you, convener, for allowing me to provide you with this update. My team and I would be happy to provide you with further details and to answer any questions that you may have.

The Convener: Thank you, cabinet secretary. Our first question is from Richard Simpson.

Dr Simpson: I am concerned that we learn lessons not just for Lanarkshire. This morning we heard from Dr Wallace and Mr Ross, who are relatively new in their posts, that along with the three new hospital directors they are taking forward an ambitious programme, which you have confirmed, cabinet secretary. That is very welcome.

The process started with the initial Monklands hospital HSMR data being above the level in July to September 2011. It was not until the summer of 2013 that we got into the rapid review progress. HIS worked with NHS Lanarkshire during that period, but clearly there was not the rapid and sustained progress that you have just said is vital. Indeed, 15 months after the initial report, the mortality figures from Hairmyres and Wishaw were also above average. Let us be kind and say that that was not an improvement.

We have a system in which HIS looks at figures, makes comments and interacts with boards. However, Dr Wallace said something very interesting this morning. He said that it might have been better to have a proper peer review at an earlier stage. HIS is not adequately resourced to examine 14 health boards on every benchmarked issue; never mind the hospital mortality ratios, there are all sorts of benchmarks for which people are more than one or two standard deviations outwith the average, and HIS simply does not have the capacity to look at that. It should not have had to come to you for a rapid review; there should have been a peer review at a much earlier stage. I agree with Dr Wallace on that.

In terms of the global system, do we not need to beef up HIS and give it a measure of requirement from the Parliament and yourselves to look at all areas in Scotland where the boards' benchmarks are outwith the average in a negative way?

Alex Neil: I will make a couple of observations and then ask Professor Leitch to come in.

I am in general agreement with you about the need for the earlier peer review, as Iain Wallace said this morning. One of the lessons that we should all learn is that we need to move more rapidly in future when such situations arise.

We have a monitoring board that meets monthly to look at performance. It looks at all the key statistics, and the HSMR is one of that wide range of statistics about the performance of boards. I have asked for closer attention to be paid to the performance of boards at board level and to the performance of the 38 acute hospitals in Scotland. On the face of it, a board might be performing reasonably well, but behind and below the board figures, there might be an issue with a particular hospital. When the partnerships are up and running, we will need a parallel monitoring system for them. When the continual monitoring process at hospital and board level identifies deviation or variation, that needs to lead to much earlier intervention from HIS or the Scottish Government. That is one of the clear lessons to be learned from NHS Lanarkshire and from a number of other issues.

We need to keep the HSMR statistic in perspective, because it is only one statistic. We should recognise that, in the situation that we are discussing, there was improvement all round. In the three hospitals in Lanarkshire, there had been a 17 per cent improvement in Wishaw and an 11 per cent improvement at Hairmyres. Even at the nadir, there was a 4 per cent improvement at Monklands. However, the Scottish average improvement was running at 12.5 per cent, and that, being three times the improvement that Monklands had achieved, should have flagged up the problem. When such a figure is flagged up in future, it should result in some kind of intervention. Initially, the board should be given its head to sort out the problem, but if it does not do so, extra resources should be brought in.

That brings me to my final point before I hand over to Jason Leitch. There is a balance to be struck between the resources that we put into the service and those that we put into inspection and scrutiny. My personal observation is that south of the border, they have gone too far with inspection and scrutiny and, as we saw in Mid-Staffordshire, that has not always resulted in better or earlier identification of problems than we have had in Scotland. At the same time, I recognise that HIS has to be staffed up so that it can do the job. The new chief executive of HIS, Angiolina Foster, will be looking at the resource requirements, and when we come to the later session on the Scottish Medicines Consortium, which is part of HIS, I have good news to report on the substantial additional resources that we are putting into the SMC. However, I accept that we need to ensure that the inspection and scrutiny side of HIS is fully resourced for the job that it needs to do.

Professor Jason Leitch (Scottish Government): We need to be clear that if the HSMR had stayed stable in Scotland since the beginning of the Scottish patient safety programme, NHS Lanarkshire would not be an outlier. If there had been no 12.5 per cent improvement across the nation, NHS Lanarkshire

would not have popped out statistically. The reason that NHS Lanarkshire is being discussed in this room today is that the improvement has not been as fast as that at other hospitals. We need to be clear that all three hospitals were improving, and Monklands was improving at the slowest rate.

I think that the accountability framework that we have in place has worked. Of course, there needs to be constant work and constant reappraisal of whether we are accessing the data quickly enough. Boards across the country analyse the data every three months when it comes out. We look at it at the chief executives meeting, at which we meet the boards. We look at it at the chairs meeting and we also look at it at our performance review meetings, not in isolation but with all the other data that we have about the delivery system.

11:15

The boards then work together to try to improve things and, in the vast majority of cases, that works—we do not need rapid reviews and we do not need to send in scrutineers. I think that that is a better system than constant scrutiny. When things do not improve fast enough, the scrutiny organisation—Healthcare Improvement Scotland—goes and looks at the situation. That is exactly what it did with NHS Lanarkshire. HIS has done that with other boards, too, and that has accelerated the change; HIS has backed away and has not had to do anything further.

In the case of NHS Lanarkshire, the improvement did not accelerate as fast. When we got new data, we decided to do something else, so we escalated things again. That escalation was the rapid review. Three months in, that review has produced 21 recommendations. You have heard evidence from the board and you heard in the cabinet secretary's opening statement that we are comfortable with the progress that it has been making.

I think that the escalation process has worked. In a system of averages, there will always be people who are not performing as well as everybody else. I have confidence in our process of scrutiny and assurance. The vast majority of improvement is happening inside the boards, without our having to do anything externally.

Dr Simpson: I do not want to throw a damp sponge over that. You are absolutely correct that what showed up was a deviation from an average that was improving—I absolutely accept that. However, in the past month we have also had the Nuffield Trust report on the comparison of the four countries in the UK, which showed that the north-east of England has made greater progress than Scotland as a whole in terms of improvements in mortality. When we benchmark the whole of Scotland's average—which is improving; we are doing well and our patient safety programme is ambitious—we have gone backwards over the past 10 or 12 years relative to the north-east of England. We need to get things in perspective.

The most worrying bit of the HIS report, apart from the issues that I raised with the first panel, is the lack of awareness of staff in NHS Lanarkshire of the patient safety programme. If that is reflected in any other health boards—we have no idea whether it is—it would be worrying. If people at the front line are not totally aware of all the pilot work that was done in Dundee, with the huge improvements that were made there, we have a significant problem.

Alex Neil: It is a general management tool—I think that we have to benchmark everything, not just the HSMR but all the key performance measurements, against what is happening in the rest of the UK and in Europe. We need to become much more outcome focused as well, rather than process focused. We have been too process focused in the past and, as you know, part of the discussion on realising the 2020 vision is about how we move to being more outcome focused.

One of the problems with benchmarking on outcomes is the dearth of reliable information. Nearly every country in Europe measures a lot of outcomes very differently and, therefore, it is very difficult to compare them. You do not want to end up comparing apples and oranges. In general, however, benchmarking needs to be a much more important part of how we measure performance, whether against the north-east of England or elsewhere. To be fair, I think that the north-east of England started from a lower base than us and, therefore, the increase might be higher.

On your second point—about staff not being aware of the patient safety programme—we, too, were extremely disappointed by that and found it to be a major issue. Immediately, Jason Leitch and HIS got to work with the other boards to establish whether it was a problem in other board areas. We have established that it is not—we are quite clear about that—and I will ask Jason to elaborate on the work that we have done to ensure that that is the case. We are not just doing a one-off survey; we will monitor the situation very closely in the future.

It is very clear that a prerequisite to the continued success of the patient safety programme is that the culture of patient safety is absolutely embedded not just among nurses and doctors, but among every member of staff. It is important for the porter, the ward clerk and everybody else to be part of the patient safety programme, which is now being rolled out to maternity, primary care and mental health as well as the acute sector.

Professor Leitch: As Dr Simpson well knows, it is a different mortality statistic in the Nuffield Trust and Health Foundation report. It is amenable mortality, which is chronic disease-related mortality rather than adjusted hospital standardised mortality, so it reflects Scotland's public health challenges rather than the safety programme. It is not about predicted versus actual deaths; it is about amenable mortality to stroke, cardiac disease and cancer. Of course, the report is still worthy of huge amounts of attention, but it relates to the speed of improvement of our population's health rather than to the provision of safe care in our hospitals—those are two different types of mortality.

I commend the Nuffield Trust and Health Foundation report to the committee. You should all read it, as it is an excellent piece of work that includes huge good news for Scotland. We do very well in swathes of that statistical analysis, including in waiting times and financial improvements. The mortality statistics in the report warrant some attention, but they are about a different type of mortality, if you will forgive me for that slightly odd statement.

I can assure the committee that nobody was more disappointed than I was to read in the Lanarkshire report that staff did not know about the Scottish patient safety programme. The report was a snapshot, so it could not analyse the 11,000 staff. However, I now have confidence in the fact that Jane Murkin has been appointed the new head of the Scottish patient safety programme; with me, she was one of the people who began the programme six years ago. She moved to a job in the Scottish Government doing other work around quality. I think that her new role is an excellent appointment.

When walking through the hospitals now, which I have done, it can be seen that the safety programme is very prominent, even for simple things such as posters and logos. Within days of her arrival in the job, Jane Murkin had a patient safety week in which a large amount of work was done with staff, patients and families to raise the profile of safety. Of course, things will not be fixed within a week, but the safety programme is becoming more visible in the Lanarkshire health board area.

Dr Simpson: Thank you.

The Convener: You heard some of the earlier evidence session, cabinet secretary.

Alex Neil: Yes, we were listening intently.

The Convener: Good. You will be able to address some of the important issues that arose during that session on how we will respond and what the boards can expect from NHS Scotland and the Scottish Government on the delivery of their plans. We are on a journey that started in 2011, but the evidence that was presented in the earlier session was that we have been a bit slow to react to some things and to do other things. Why did it take your review and the instruction for HIS to go into NHS Lanarkshire to get a substantial package of action and, indeed, posters in the wards?

Alex Neil: My impression of the earlier session was that Ian Ross and Iain Wallace undersold a bit their own progress since 2011. As Jason Leitch said, it is an escalation process and, in fact, substantial progress had been made in Lanarkshire. I quoted the figures for Wishaw hospital, which saw a 17 per cent reduction in the HSMR. In addition, Hairmyres hospital saw an 11 per cent reduction and Monklands hospital saw a 4 per cent reduction. Obviously, that was not nearly good enough compared with the average figure for the other two hospitals in Lanarkshire or with the Scottish average, which is why we did the final escalation of the rapid review. However, I do not think that we should underestimate the progress that had been made since 2011. If I were to criticise the evidence that was given earlier, I would say that the witnesses undersold a bit the progress that had been made in the past two or three years.

The Convener: Of course. That is because they are not politicians, which is pretty good. [*Laughter*.]

Paul Gray (NHS Scotland): They will be delighted to hear that.

The Convener: I have a serious question about the escalation process, because you are presenting it as a process in which lots of the work is done internally. The internal evidence and evidence from outside the organisation should have been being used to drive work to identify failings and to inform senior management and so on. You say that the boards were making progress—you referred to 17 per cent and 4 per cent reductions—so why did the process have to be escalated? If they were making progress and everybody was happy, why were you sticking your nose in there?

Alex Neil: The reason comes back first to the very relevant point that Dr Simpson made about the timing of the peer review process. One of the lessons internally in Lanarkshire, which should be learned right across the system, is that the peer review process should have happened earlier. Had that happened, it might well have been the case that things would not have got to the stage at which our rapid review was required.

The HSMR is a trend over time. It is not possible simply to act on the basis of one quarter's statistics. The trend in Monklands was not moving

fast enough. When that became clear, we intervened.

I will ask Jason Leitch to give you some more detail about the process.

The Convener: Professor Leitch addressed the other point that Dr Wallace made earlier, when he suggested—he did not plead—that he was being set a higher standard. There are other boards with higher mortality rates, he suggested, I am sure. Is that correct? You were watching the evidence. I am looking to committee members, too. Dr Wallace suggested that there were higher mortality rates in other board areas.

Professor Leitch: We could get into a very technical discussion on mortality statistics, which is not where you want to go. I can do it, though.

The Convener: You can try for us. You could perhaps write it down for us or something.

Professor Leitch: It is not that you would not get it but that it takes a while.

There are multiple ways of measuring mortality, and we have just discussed two of them. The HSMR is a way of measuring or estimating predicted deaths and actual deaths. It therefore gives a ratio. If the predicted number of deaths is the same as the actual number of deaths, the ratio is 1.0. That single number summarises something about safety and quality in the institution concerned, but it should never be taken in isolation. The danger of all these conversations in these settings is that people think that we should take the HSMR in isolation and make decisions from it. That is not what should be done—and nobody suggests that it ever should. However, the HSMR is like a smoke signal, warning us that we should perhaps go looking for safety and quality concerns.

Apart from having that single ratio, which we publish every quarter for every hospital in the safety programme, we also monitor the HSMR trend over time. We take all of the dots—all the 1.0s, the 0.89s and the 1.2s, for instance—and we chart them on a graph. The clever statisticians draw me a line through those dots, and the slope of that line gives me the percentage reduction. That is what the 12.5 per cent that you keep hearing about is. The slope of that statistical line is 12.5 per cent for Scotland. The slope of the line does not depend on where it starts; it depends on the improvement.

Iain Wallace is correct in one sense, but Monklands has been the slowest improver among our major hospitals. Monklands has the least steep curve in the line, if you understand what I am saying.

There are other hospitals with a higher HSMR as a ratio, but they have had dramatic improvements, and the improvement is what we care about. The movement from the beginning of the safety programme—from the beginning of 2008 until now—is what we have staked our outcome aim on. That is why Crosshouse shows a 30 per cent reduction. The Western general has a lower reduction, but it has a very low HSMR, because it started with a low HSMR and it is difficult to improve from a very low position. Each case is taken in isolation. The reason why we considered Lanarkshire and Monklands in particular was that the slope of the line was not as steep as for the other hospitals in Scotland.

The Convener: So there is no smoke on the hillside from any other board, and no other board is on that escalating journey that you described earlier.

Professor Leitch: The new statistics come out at the end of May, but there are no boards presently on that escalation scale.

The Convener: But you do not just consider things on a quarterly basis; you consider the trend, do you not?

Professor Leitch: Correct, but—

The Convener: So, there is nothing about the trend that is alerting you to—

Professor Leitch: There are no outliers—

The Convener: There is no puff of smoke on some hillside by Helensburgh or wherever.

Professor Leitch: Or Inverclyde—no.

The Convener: In Inverclyde, more importantly.

Professor Leitch: No, there are no hospitals that are presently outliers within the HSMR data. We get that knowledge every three months, as do the boards. The boards get it, and I get it after the boards get it—it is for internal consumption.

The Convener: So NHS Lanarkshire got it, too.

Professor Leitch: Correct.

The Convener: But it never acted on it—or it did not do so quickly enough.

Professor Leitch: Safety is not done as an issue for NHS Scotland. On the HSMR, I do not think that just because everybody is average and inside the pack, we can all sit back and say that all is well. Safety is a constant fight and it will never be done. It will not be done by 2017—referring to the evidence that you got earlier—and it will not be done by the time Iain Wallace and Ian Ross retire. It will never be done, because it is a constant fight against the complexities of human illness and of the big systems that we work in. That is why the Scottish patient safety programme exists.

11:30

Bob Doris: I will reiterate some of the stuff that I said during the previous evidence session. I will try to stay away from puffs of smoke, JFK assassination theories, grassy knolls and all those kinds of things. I asked NHS Lanarkshire what steps it is taking now that it has realised that it had become an outlier. A whole host of examples are in its action plan, but I figured that NHS Lanarkshire's representatives might pick out in oral evidence the ones that they thought were most significant. The first of the two examples that they gave was about listening more to patient opinion. When I asked what they meant by that, they detailed that they will look at patient complaints on a site basis, identify any trends on a monthly basis and, if it is appropriate, take action on a quick turnaround from month to month. They also talked about an additional £3.1 million investment being made in nursing to, in particular, free up nurse ward managers to move away from front-line nursing duties and have a more strategic role.

NHS Lanarkshire gave those two examples. Does such action happen as a matter of course across NHS Scotland when a trend is identified? I would rather that there was not an outlier, but in my questions I was trying to get at the point that no hospital is ever perfect. We would like them to be perfect, but all that we can hope for is that when the statistics start to show that things are amiss, the NHS acts quickly. Are you confident that health boards across Scotland identify the possible emergence of a trend and act accordingly and quickly? One of the committee's biggest concerns is that it seems that the organisation was not as fleet of foot as it could have been.

Alex Neil: I will give you a multifaceted reply, Bob. First, in NHS Lanarkshire, the board needed to ask more searching questions. Had the board asked more searching questions, it might have insisted on prompter action. That is the board's job, as it is there to scrutinise, to hold to account, to enable and to support. One of the things that I have done since I came into this job is to look at how we can strengthen not only the board of NHS Lanarkshire but all NHS boards, because I believe that some of them have not been proactive enough in scrutinising the performance of their executives. In some cases, the balance of executives to non-executives needs to be redressed so that scrutiny and accountability are substantially improved.

One of the big issues in all our hospitals is that people often do not know whom to complain to when something goes wrong. As you know, NHS Lanarkshire is appointing a site director in each of the three hospitals. We are reverting to where we were 30 or 40 years ago, when there was a general manager, a matron and a medical superintendent. In effect, on each of the three NHS Lanarkshire sites, there will be a director, who is the top dog at that site; a senior nurse—in the old days we would have called her the matron; and a senior clinician. They will be the core.

Furthermore, I have suggested—and NHS Lanarkshire will do this—that when people walk into Monklands hospital, Hairmyres hospital or Wishaw general hospital, they will see those three faces, meeting them, welcoming them and saying, "My name is Ms Roberton and I am the director for Monklands hospital. If you have any issues, here is how you contact me by phone, by text or by email," or whatever, and the same for the head nurse and the head clinician. Such visibility of the senior management on site—not in a remote board headquarters—is an essential part of the improvement process. I want that structure and that approach to be rolled out across all 38 acute hospitals in Scotland as soon as possible. That is on top of the patient opinion website and all the other things that were outlined in the previous evidence session.

It is absolutely key that people feel that they know whom to phone or contact. They want a name and, ideally, a face. That kind of procedure will highlight much more quickly things that might not be life threatening or safety issues but which are unacceptable, and it is one of the things that I want to see not by December this year but immediately, once all the nine appointments have been made.

Bob Doris: From what you are saying, it appears that some health boards might have been painted into a position where they are not analysing their own data enough. They might be very good at giving it to HIS or the information services division as requested, but they are not necessarily good at analysing it themselves in order to take quick enough action.

I very much welcome the workforce and workload management tools that are now in place across the NHS, but would improvement or a lack thereof in mortality rates feed into a health board's workforce or workload management plan? For example, we have heard about the additional nurses in NHS Lanarkshire, which are welcome, but I am trying out to work out whether those additional nurses and, more important, where and how they have been deployed arose because a particular problem had been identified or whether the two things happened to occur at the same time.

Alex Neil: In fact, the decision was informed by the new workforce planning tool, which we made mandatory from April last year. Although the two things coincided, the same conclusion was—if you like—reached from two different directions: first,

through the report; and, secondly, by applying the workforce management tool to nursing numbers and the skills mix. That clearly demonstrated the need for an additional 150 or so nurses, even though over the past seven years or so there has been nearly a 10 per cent increase in the number of full-time equivalent nurses in NHS Lanarkshire. As I have said, that came out of the workforce planning tool but the conclusion that the nurses were needed was also reached as part of the review process.

Bob Doris: Would comparative mortality rates better inform the whole process?

Alex Neil: There is a whole suite of performance statistics, and every health board should be looking at every hospital every month. NHS Tayside is particularly advanced in the management tools that it uses. As was mentioned in the previous evidence session, we are doing away with whiteboards and putting in a computerised whiteboard system that has been piloted in Tayside and the Borders. That system, which should be fully up and running in every ward and acute hospital in Scotland within the next year or so, is able not just to give real-time information for a particular ward or department such as A and E but to assimilate that information, measure trend analysis over time and collate the data at hospital, board and, eventually, national levels. I believe that we need that kind of real-time management information to manage a 21st century health service.

Professor Leitch: Comparing mortality in a hospital with that in another is a very dangerous game; comparing mortality in your own hospital with historical mortality rates is a much more robust process. It is hugely difficult to compare, say, the hospital in Larbert with Edinburgh royal infirmary because of the different demographics and the different services that they provide and, as a result, we try to avoid league tables of mortality. That said, one of the reasons why we are here is the trend in hospital mortality over time.

My other brief point is that these hospitals do not exist in isolation. We do not say to Lanarkshire, "Off you go and improve mortality and let us know how you get on." The Scottish patient safety programme analyses over time and globally the work to reduce avoidable mortality and to improve safety in Scotland's hospitals. For the first five years, we concentrated on infection reduction, patient safety walkarounds, Clostridium difficile, hand washing and so on; indeed, members could almost write the list themselves. We have reached 12.5 per cent, and our aim is to get to 20 per cent by the end of 2015. It is a very high-level and hugely ambitious aim; indeed, no other country in the world has it.

Nationally, we—the leadership of the safety programme and of NHS Scotland—now need to look at what the gaps are in getting us from 12.5 per cent to 20 per cent. We believe that two of the big areas in there are the early management and treatment of sepsis, which is a hugely complex disease that is difficult to spot, and the early rescue of deteriorating patients. Each of the boards is now working on fixing or helping to fix those two areas. NHS Lanarkshire is no different. It has specific aims in its plan on sepsis and deteriorating patients. It is not just Lanarkshire; the whole system is working on those two issues.

In a year's time, I may come back to the committee and say, "Sepsis and deteriorating patients look good. Now we're concerned about this other thing." The safety programme continues to evolve to keep up with what is happening globally.

Richard Lyle: Cabinet secretary, you have listened to our discussion about the 21 recommendations and more than 100 action points. In your view, what went wrong in Lanarkshire? When HIS called for evidence recently, I attended a meeting where someone suggested—I will not say who; it was not me—that we have too many hospitals in Lanarkshire. Would you agree? I would disagree with that comment and would wish to retain the three hospitals and three A and Es in Lanarkshire. What is the Government's opinion?

Alex Neil: I will give a wider answer, in respect of resources. The burden on the finances of NHS Lanarkshire is much higher than the burden on any of the other boards, with the possible exception of Lothian, because of private finance initiative charges. I make that point not for party-political reasons; it is just a fact of life that one quarter of all the PFI charges in the national health service in Scotland are in NHS Lanarkshire, because Wishaw and Hairmyres are PFI hospitals. This year, nearly £50 million of NHS Lanarkshire's budget will be used up in PFI charges. If those hospitals had been funded using the traditional method, that figure would be substantially less than £50 million. To be fair to NHS Lanarkshire, it faces a particular challenge, which many other boards do not have. That is point number 1.

Point number 2 is that I have seen no evidence anywhere, in this or any other exercise, that tells me that the performance of NHS Lanarkshire has been adversely affected by having three acute hospitals or, indeed, three accident and emergency departments. For those who are saying that we should reduce the number of acute hospitals in Lanarkshire, the immediate issue is where we would put the capacity of the hospital that we close down. Presumably we would need to put it in the two remaining hospitals. It is difficult to

see how we could reasonably do that, given the geography of Lanarkshire, the current status of Lanarkshire's hospitals and, in particular, the complication of the PFI arrangement. I do not think that anything other than a three-hospital future is the way ahead for NHS Lanarkshire.

Having said that, there is evidence that some services that are currently carried out on two or three sites should be carried out on one or two sites. We will have to face the facts. If the medical evidence—which I am more concerned about than the financial evidence—shows that there is a need to focus some services on fewer sites, that is a proposition that I will have to take seriously. However, there is already a degree of specialism on the three sites: Monklands has basically become the cancer capital for Lanarkshire, for example; Hairmyres leads on cardiac services; and Wishaw leads on paediatrics and maternity. I am not suggesting that we should go down the road of all three being specialist hospitals—they are three general, acute hospitals—but from time to time, we will undoubtedly need to focus some services on a smaller number of the sites than is currently the case. We should not close our minds to that option if it is medically the right thing to do, but in general terms, we need the three hospital sites in Lanarkshire.

11:45

Richard Lyle: Thank you for that. I certainly agree with your comments. Earlier, I mentioned to Dr Wallace and Ian Ross page 18 of the March report in relation to having consultants in NHS hospitals, which are open 24/7, 52 weeks a year, at the weekends. Are we finding that weekends are when a lot of the problems are being flagged up, because we do not have enough consultants on? We were told earlier that most have consultants on until 11 pm and I know that some consultants are sleeping in the hospital in order to advise as required. What is your view on the situation as regards consultants in NHS Lanarkshire?

Alex Neil: I will give a two-pronged reply. First, we did some research last year, long before the issue with HSMR in Lanarkshire came up, led by Jason Leitch—I will ask him to say a word or two more about it later—to identify whether mortality rates were higher in Scotland at weekends than they are during the rest of the week. There is no evidence that such a pattern exists in Scotland.

I believe that Jeremy Hunt thinks that such a pattern might well exist down south in some hospital areas, but there is no evidence to suggest that people are less likely to die during the week than they are at the weekend in Scottish hospitals and Lanarkshire does not appear to be an exception to that rule. In other words, mortality rates at the weekend are not markedly higher than mortality rates during the rest of the week, so we need to put that concern to rest and put that point on the record.

On the more general question of consultants, let us take the example of A and E consultants in Lanarkshire. Seven years ago, there were eight A and E consultants covering the three A and E departments in Lanarkshire; today, 29 A and E consultants cover Lanarkshire, so there has been a substantial increase. In general, from memory, there has been over the past seven or eight years or so an overall increase of somewhere between 40 and 50 per cent in the number of consultants working out of NHS Lanarkshire.

The real problem, which was referred to earlier—and it is not a Lanarkshire problem, nor even a Scottish problem; it is a UK problem—is that it is difficult to attract junior doctors to work in A and E, in particular in anything involving out-of-hours work. Quite frankly, the modern medical graduate is not prepared to do what people of Dr Simpson's generation, for example, were prepared to do as regards working out of hours. We have a similar problem—a similar pattern, or a similar challenge—around recruiting GPs. Ian Ross referred earlier to the general issue of out-of-hours services, which are being reviewed in Lanarkshire.

Although some parts of the solution can be found locally, we also need to do more nationally on out-of-hours services. For example, the overtime rate for out-of-hours work varies between boards, so we need to look at standardising the overtime rate across Scotland for out-of-hours work. We also need to look further at the interaction with and use of telecare to avoid the need for out-of-hours care.

We need to tackle the problem in a range of different ways; it is not a simple problem that will be solved by putting in more doctors. However, in some specialties in Lanarkshire there are undoubtedly challenges in recruiting people, as there are throughout the country—Lanarkshire is no exception. The exceptions tend to be the four university hospital cities: Glasgow, Edinburgh, Dundee and Aberdeen. On the whole, they have less difficulty in recruiting people because of the university connections and because of their very nature—they are bigger and are in cities—although they have problems too. For example, because of the cost of living and accommodation issues in Aberdeen, there are major challenges in recruiting even senior consultants in the Aberdeen area.

The picture is complex and mixed, but on the whole I would not say that NHS Lanarkshire is any better or worse off in facing those challenges than other boards are, such as those in Fife, Ayrshire, Forth Valley, Borders or Dumfries and Galloway.

Professor Leitch: I have confidence that Dr Wallace understands the issues locally, in Lanarkshire. They are not simple; they are incredibly complex. Senior decision makers early in a patient's journey are important in considering safety, because the safety of the rotas for the provision of care should be the most important thing across NHS Scotland—never mind service provision. That means that the attractiveness of the rotas should be considered, particularly for trainees, because that influences where they choose to work—whether they choose to work in Carlisle or in the Glasgow royal, for example.

That then brings into sharp relief the provision of services across three sites. NHS Lanarkshire has taken that into account and has vascular surgery on one site, so the vascular trainees are in a rota on one site. The HIS report mentions in particular orthopaedics and says that there is scope to think about redesigning orthopaedic services across the three hospitals. That would not mean in any sense closing a hospital, but it would mean changing in particular the provision of trauma orthopaedics—what we call hot orthopaedics—to have that on perhaps one or two sites rather than the three sites as at present.

NHS Lanarkshire should be able to have those conversations with its staff and its patients and their families. The cabinet secretary has said publicly that he is comfortable with hearing about such plans if safety and quality are the number 1 concerns for the institution.

Richard Lyle: Thank you.

The Convener: Are safety and quality served by having three accident and emergency departments or are we moving towards something else, given the cabinet secretary's recent comments on trauma centres?

Alex Neil: The four trauma centres that I announced will take 0.3 per cent of A and E throughput in the whole of Scotland. It is a specialised area. Once they are fully up and running, about 1,000 patients will go to the trauma centres over the space of a year.

We have to look at the issues as a whole. Rather than looking at how many A and E departments we have—whether we have three, two or one—we have to look at how we manage the patient journey from A to Z. For example, I see a big, expanded future for the ambulance service's medical provision. There is a lot of skill in the ambulance service and we are continually upskilling it. I think—as the ambulance service told the committee recently—that there is a lot more scope for decisions to be made when an ambulance goes out about whether somebody needs to be admitted to hospital.

One of the most interesting figures in the HIS report on Lanarkshire was the 30 per cent of patients who were in hospital when the report was prepared who did not need to be in hospital. We know that that is not an aberration in Lanarkshire but is a general thing. NHS Borders did an audit a few weeks ago and it estimates that 36 per cent of its patients did not need to be in hospital.

Such issues are the priority issues, because if we are able to keep out of hospital people who do not need to be there, we gain all round—in A and E, on the quality and safety of care and, most important for the patient, because health outcomes for people are much better when they can be treated at home than when they are treated in hospital.

We need to take the debate beyond whether there should be two or three A and E departments, because the debate is much bigger than that. Particularly in the context of our 2020 vision discussions, the wider issues are key and are of a higher priority.

Rhoda Grant: Why was progress on improvement so slow in Lanarkshire?

Alex Neil: I do not accept that it was slow. As I said earlier, there are lessons to be learned about process. Richard Simpson rightly focused on the need in such circumstances for much earlier peer review, and that is one of the main lessons that we can take from Lanarkshire. However, when we look at the progress that has been made, whether it is the recruitment of additional consultants and nurses over the past two or three years or the improvement in the HSMR—let us remember that it was a significant improvement—we see that substantial progress has been made.

I think that progress could have been made more quickly and that it could have been better, but I would not describe the progress as slow. By any standard, it was still significant progress.

Nevertheless, Rhoda Grant is right—we should learn the lessons. Richard Simpson's point that the peer review should have taken place at an early stage is absolutely right. That is one of the lessons that we need to learn.

Rhoda Grant: I suppose that I could ask why, if progress was not slow, you asked for a rapid review to take place. It is obvious that concerns were raised with you, such that you felt that you had to intervene. HIS was involved from 2011 and two years later you intervened.

Alex Neil: As I said in answer to Richard Simpson and to the convener, it is an escalation process. We had anticipated that greater progress would have been made, so we decided that the final escalation—in other words, the rapid review—was required.

I do not think that a rapid review would have been undertaken in 2011 or 2012, because it was necessary to know about the history and to have the experience of what had been tried and what was working and what was not. An escalation process was used. That said, I accept the point about the need for earlier peer review—Richard Simpson and Iain Wallace are absolutely right about that.

I do not know whether Jason Leitch wants to add anything.

Professor Leitch: Only to say—at the risk of repeating myself—that the world is jealous of the work that Scotland has done on patient safety. NHS Lanarkshire is a bit of a victim of just not going as quickly as the rest of the country. The Danes, the Swedes and the Norwegians, for example, are copying the work that Scotland has done on patient safety.

That is not to say that we are complacent or to suggest that we should let boards go slowly—quite the opposite. As soon as we saw that NHS Lanarkshire was not going as quickly as we would have liked, particularly in Monklands hospital, we engaged with it. It now has 21 recommendations that it is implementing.

There are reasons why NHS Lanarkshire went more slowly; the report gives those reasons. There were some leadership issues and some issues with the visibility of the Scottish patient safety programme. There were also some data and safety walk-around issues. The 21 recommendations address those reasons for NHS Lanarkshire going more slowly—for want of a better description—than the other hospitals in Scotland. That is why the HIS review was carried out. We now have the recommendations, to which I and the cabinet secretary think that NHS Lanarkshire has responded very adequately up to this point, and we will continue to monitor its progress.

Rhoda Grant: I am glad that you have stressed that you will not be complacent, because the statistics that we are talking about represent people and their experience as patients. We should always strive for perfection, or as close to it as is possible.

Given that, does HIS have the right powers? Given that the cabinet secretary has said that he believes that the peer review should have taken place sooner, is it within HIS's powers to do that before a rapid review is instigated? Can it pull in the necessary resources and use those powers at an earlier stage?

Alex Neil: Absolutely. If HIS decides that a rapid review is necessary, it could take the decision to carry one out. It would inform me, but it would not necessarily come to me for my permission. It used to be the case that, when a joint inspection was required by the Care Inspectorate and HIS, they submitted a proposal to the cabinet secretary for approval, but I said to them that if they agree that a joint inspection of any institution, department or situation in Scotland is required, they should go ahead and carry it out rather than wait for my permission. If a joint inspection is required, they should do it. We employ the people in those bodies to make a professional judgment. Obviously, they should inform us about what they are doing, but they do not need to wait for my explicit permission to carry out a joint inspection.

I have looked at the inspection regime south of the border, which, in law, appears to be more independent than the inspection regime in Scotland, but I am not convinced that it is more effective. I think that we move more speedily and more effectively. HIS has total operational independence. If it decides to go into a particular hospital to carry out an inspection, it does not come to me for permission. It sets up its own remit and timing and it appoints its own inspectors and public partners. Neither I nor my officials have any direct involvement in that. Sometimes, HIS rebukes us and makes recommendations about what we—as well as health boards—should do in certain situations.

The system in Scotland is working better, more effectively and more speedily than that south of the border. That is not a constitutional argument but an observation.

12:00

Rhoda Grant: It is not a constitutional argument, given that you have the powers to do things differently in Scotland at the moment.

Does HIS have the necessary resources? Did you have to ask for further resources for the rapid review to be carried out? Can HIS pull in such resources?

Alex Neil: We must understand that HIS has two sources of resources, one of which is dedicated HIS staffing. However, for the exercise that we are discussing, two groups were set up—a medical group and a governance group—which were staffed by people who were by and large external to NHS Lanarkshire. HIS uses people from elsewhere in the system; people who are not in the system, such as retired people and academics; and people who cross a number of lines, such as Sir Lewis Ritchie, who was a key member of the governance group.

HIS makes full use of all the resources and it reaches agreement with people on remuneration—we are not directly involved in that. Sometimes, HIS consults us to ensure that we are

content that somebody has the right qualities and is sufficiently independent, but it makes the decision at the end of the day.

We have regular performance meetings at official and political levels with HIS's senior management. If HIS requires additional resources for inspection and scrutiny, we will do what we have done on access to new medicines and make those additional resources available.

Rhoda Grant: Did HIS need additional resources for the rapid review process?

Alex Neil: Not particularly. The governance group was led by Jeane Freeman, who chairs the Golden Jubilee national hospital's board. It also involved Sir Lewis Ritchie from NHS Grampian and Malcolm Wright, who is NHS Education for Scotland's chief executive. Those resources were readily available for HIS.

Rhoda Grant: Do the other health boards that provide staff to undertake peer review give those staff freely? Do they cover those costs?

Alex Neil: That is the case but, if a health board required additional resources to cover for somebody, we would ensure that those resources were available to it. We would not let such issues stand in the way of getting the right people to do the job.

Rhoda Grant: HIS can deal with that at its own behest at any point.

Alex Neil: Absolutely.

The Convener: Is it a new arrangement for HIS to have the ability to kick off a review independently? We keep a check on the hospital reviews, which your predecessor instructed. The NHS Lanarkshire review was instructed, as was the additional work for prisons and so on. Is there an example of HIS setting off and letting you know that it has started a review of A, B and C? Will that happen in the future?

Alex Neil: I make it clear that HIS takes the decision to do the bulk of its inspections. I can ask HIS to do a review, too. For example, I have received representations from MSPs about alleged problems in particular hospitals. I have been in my job for nearly two years and, in that time, I have occasionally asked HIS to undertake an unannounced inspection of a hospital where problems appear to be arising. However, HIS takes the decisions on the bulk of inspections. If it wanted to inspect Raigmore hospital today, it would just go and do that—it does not need my permission.

The Convener: Yes, but its work programme is set out by you.

Professor Leitch: But not by location

Alex Neil: Not by location.

The Convener: I am not suggesting that it is by location, but it is set by you.

Alex Neil: The overall work programme and the framework to which HIS works are set out by me, but the decisions about which hospital to inspect, when to inspect, who does the inspection and who the public partners will be are all decisions for HIS.

The Convener: Perhaps we should speak to HIS. It has been involved in Lanarkshire since 2011. It saw slow progress, and there were reports. Why did HIS not instigate a review much sooner?

Alex Neil: I am sure that Robbie Pearson, who led for HIS on the initial report into Lanarkshire, would be more than happy to give evidence to the committee.

The Convener: I am sure that he would—I look forward to it.

Professor Leitch: I think that he would tell you that he followed the escalation procedure that was in place. HIS engaged with NHS Lanarkshire appropriately, and NHS Lanarkshire responded. The data did not move as quickly as NHS Lanarkshire or Healthcare Improvement Scotland would have liked, so Robbie Pearson then escalated the issue to the Scottish Government and we set up a rapid review.

The Convener: As members have no further questions on the issue, we move to the next agenda item.

Access to New Medicines

12:06

The Convener: Cabinet secretary, do you wish to make a statement?

Alex Neil: I have a very brief statement, if I can find it.

The Convener: I hope that it is briefer than the previous one.

Alex Neil: It is much briefer—it is one side of an A4 sheet, which I know you welcome.

I welcome the opportunity to talk to the committee again about access to new medicines and about the questions that the committee raised in its letter to me in March. We are making progress in line with the committee's recommendations. Most significantly, submissions are being put to the Scottish Medicines Consortium that will potentially fall within the new approach that is set out in its report. If that approach is realised in the way that the SMC report suggests, it will be a significant improvement for patients in Scotland, and I know that others around the world are already taking interest.

The committee asked me about the financial implications of the new approach, SMC resourcing and individual patient treatment request changes, and I am happy to answer any questions that you have.

The Convener: Thank you for that brief statement.

Bob Doris: We all welcome the cross-party consensual approach that the committee has taken consistently to access to new medicines and the individual patient treatment request system, which is undergoing change.

Some of us are particularly keen to get more information on the transition period. I should put it on the record that I have made a number of representations to the cabinet secretary about one particular constituent and a previous unsuccessful individual patient treatment request relating to an ultra-orphan medicine. I hope that a new request will go in soon. I will not go into the details of that, but the situation illustrates the specific point that, depending on when that request goes in, it will be dealt with under what we hope will be the new flexible IPTR system or under the so-called PAC system—the peer-approved clinical system. There is a nervousness that some patients could fall between two stools, and we are keen to ensure that that does not happen in the transition process.

On the timescale, do you have a definitive date or an estimate of when we will switch from what we hope will be the more flexible IPTR system to the PAC system?

Alex Neil: First, our plan has always been to move to the new system by May of this year, and we anticipate that every board will be able to do that. Secondly, we have made it absolutely clear that, in the interim period, there should be maximum flexibility and that the IPTR process should have regard to the new and more flexible system that we are introducing. I looked at the submission from the Beatson oncologists and we have spoken to NHS Greater Glasgow and Clyde to ensure that it is in line with every other board in Scotland in applying a more flexible approach that is in line with the philosophy that we are now pursuing.

For me, the key issue is to ensure that, when a patient would benefit from a particular drug within a reasonable time period and the benefit is genuine and reasonably long lasting, the patient should get the drug. My understanding is that that is now happening in Glasgow, as it is throughout the rest of Scotland.

Bob Doris: You have presupposed my next question, which is on concerns about the Beatson west of Scotland cancer centre, the west of Scotland cancer network and the fact that four health boards make referrals to that facility. Following their evidence to the committee in February, the oncologists again raised concerns, but I note that NHS Greater Glasgow and Clyde refers in its submission to a policy that was agreed to by the Scottish Association of Medical Directors and which gave rise to

"optimism that an NHS Scotland consensus could emerge"

on an

"interim arrangement which will be displaced when PACS is implemented."

However, it is now hoped that there will be one process for IPTRs at the Beatson to ensure that the place to which the patient is referred, not the board that refers them, decides on the IPTR. Is that the situation just now with the Beatson?

Alex Neil: I will ask Kathryn Fergusson to give you the exact detail, but I have to say that I found the Beatson oncologists' evidence a bit strange. The week before they submitted their evidence, they met Greater Glasgow and Clyde health board and apparently raised none of the issues in question. We got in touch with Glasgow, and my understanding is that there is now a clear way forward in Glasgow as there is throughout the rest of the country.

Kathryn Fergusson (Scottish Government): Mr Doris is quite right about the process that Glasgow has described in its letter. The committee might recall that in June last year, before it

reported on its inquiry, the cabinet secretary asked HIS to look at a specific case involving the Rankin family in Ayrshire and its particularly poor experience of the process. The subsequent report contained some quite helpful commentary about cross-board working between health boards, and what emerged quite strongly from that and from our conversations with patients and their families was the importance to those who are going through the process of putting the clinician and consultant who knows them best at the heart of the process. As a result, what we want in the PAC system is for the clinician and consultant to be part—indeed, at the heart—of the decision making. It is quite right that the process that Glasgow described in its letter has been going on for some time now, but HIS's work identified certain changes in the process that we needed to be aware of and their pros and cons.

Mr Doris mentioned the Scottish Association of Medical Directors's discussion about the Glasgow approach. I understand that the issue was discussed again at the association's last meeting, which took place only a couple of weeks ago, and although the medical directors noted the Glasgow approach there was no indication from other health boards in the rest of the country that in the interim they were going to change what they were doing—which would appear to us, as people on the outside looking in, as embracing the flexibility that was requested in the committee's report and by the chief medical officer.

Bob Doris: I am sure that the committee is keen to move on, but I think it important to ask this question for the sake of clarity. Given that four health board areas use the specialisms at the Beatson centre, concern has been expressed that the situation for patients at the same facility could vary according to the flexibility that is demonstrated in each health board area. Are you confident that that situation has been smoothed out and that there is a consistent approach to dealing with interim IPTRs between now and the introduction of the new PAC system?

Kathryn Fergusson: From the high-level information that we have—I must stress that it is high level, because we as the Government do not have access to the confidential patient information that we could get someone suitably qualified to trawl through—it seems to us that there has been a shift in approach. However, I must sound a note of caution. There was a lot of talk about statistics earlier; we might be talking about very small patient numbers here, but we are also talking about people and their families, and when we refer to small patient numbers, we should remember the impact that the situation has on those patients and their families. However, as I have said, the very high-level data suggests to us that there has been a shift in approach in Glasgow and elsewhere in the west of Scotland.

Alex Neil: As a general comment, one of the things that motivated me to change this policy was ensuring that there was no postcode lottery in Scotland with regard to access to new medicines. I will take whatever action I need to take to ensure that there is no such lottery, because I think that people who are in Glasgow, whatever health board area they are from, should have exactly the same access as everyone else in the rest of Scotland. We will ensure that that happens.

12:15

Bob Doris: My final question is on what you said about a medicine improving a patient's condition and that being backed up by specialist advice in relation to an IPTR or the peer-approved process. If a medicine would stop a condition deteriorating, would that be regarded as an improvement in the patient's condition? I am thinking about a particular case in my constituency, which I know is a dangerous thing to bring up at committee. However, I am pretty close to that case.

Alex Neil: The key criterion is whether the patient will benefit. I am not a medic and I will defer to the two medics around the table, but as a layman I would regard a medicine stopping a deterioration as benefiting the patient.

Bob Doris: I will draw that to the attention of the board of NHS Greater Glasgow and Clyde. I had to indulge myself there, convener, because I want to ensure that my constituent gets the best representation that they can.

The Convener: Indeed. I am sure that you are working hard on their behalf.

I seek further clarification from the cabinet secretary on the issue that is at the heart of the Beatson situation. I do not know whether that has been ironed out by scaling everybody down at the Beatson, but the correspondence that we have received, including that which followed our subsequent request for information from the various boards, shows that there seems to be, as Bob Doris suggested, regional variation. It seems that more flexibility is being applied in NHS Ayrshire and Arran and that it is in tune with and acting in the spirit of the instruction of the chief medical officer; it has responded in a slightly different and more positive way, and more people are getting access to medication. Of course, that is being delivered at the Beatson. However, the same flexibility is not applied to someone who lives in Greenock, for example.

No one round the table is suggesting that you, or your representatives in the Scottish

Government, have not tried to communicate the message about flexibility effectively. We have seen all the correspondence in that regard. However, at this stage, there still seems to be a need for clarity and resolution, and to clear up the difficulty of the concern regarding NHS Greater Glasgow and Clyde in particular, which it seems has not been resolved. It needs to be resolved, because we are dealing with individuals and their families.

We knew that there would be a problem in the transitional period. We highlighted that and spoke about it in debate, committee meetings and so on. However, we are months on now and the situation needs to be sorted out for people who will have shortened lives anyway.

Alex Neil: I expect the Glasgow health board, like every other health board, to follow the Government's policy, which has been made clear consistently. We have been monitoring the situation and we think that the problem has been resolved. However, if we have to intervene to ensure that there is no postcode lottery, we will do that.

The Convener: There seems to be a dragging of feet.

Alex Neil: If people give us evidence that shows that there is still a blockage, we will address that.

Kathryn Fergusson: We have said that all along. Without knowing specific details, it is always difficult to comment. However, for the handful of cases that have been drawn to our attention—the case of Mr Doris's constituent is one of them—we have been able to ask questions of the health board, with appropriate permission from the patient. It depends on how much we can judge from what is in the ministerial mailbag or from the people who go to MSPs' surgeries, but we follow up all such cases. As I said, we have had just a handful of cases, but if members are aware of any other cases, I ask them please to let us know.

The Convener: Work was done by the cabinet secretary, this committee and others so that the situation that Bob Doris has just gone through in pleading the case of an individual constituent would be avoided. The work that was done was supposed to sort all that out, but it has not been sorted out and it needs to be.

Alex Neil: My impression was that it had been sorted, but if it has not been, give me the evidence and we will sort it.

The Convener: Well, go and get the evidence—shake the tree. The health board has issues that it is not being completely clear about, whether they are linked to costs or detriment to other patients. The submissions seem to show that there is an underlying issue. I agree that only a small number of individuals are involved, but they are in very difficult circumstances and are paying the price for this bureaucracy.

Alex Neil: If there are still cases like that, we will talk to Glasgow again. We have reiterated to Glasgow the Government's absolutely clear policy, and I expect every health board, without exception, to follow that policy.

The Convener: It is just the health board's interpretation.

Gil Paterson (Clydebank and Milngavie) (SNP): We had the SMC speak to us on 25 February. I want clarification of what new moneys were available for putting the new system in place. I will read from the *Official Report* of that meeting. The convener asked:

"Does the funding of £1 million that was announced reflect accurately the amount of resource that you believe you need to do that job? Did you bid for more than £1 million?"

In response, Professor Timoney, who is the chair of the SMC, said:

"It will cost far more than £1 million to do the work, but we are a cost-efficient organisation. We put in a bid for something like £1.1 million."

That does not represent a great disparity, in my view, but the convener pursued that line of questioning. He asked:

"What is your estimated price tag for being able to do the job proficiently, quickly and properly?"

Professor Timoney said:

"We have not produced an official estimate for that. My personal estimate was that the price would be substantially more than £1 million"

although a bid had been made for £1.1 million. The convener continued to press the witnesses and asked:

"Would the estimated cost be above £1.5 million? Would it be £2 million or £3 million?"

Professor Timoney replied:

"It is more like £2 million",—[*Official Report, Health and Sport Committee*, 26 February 2014; c 4972.]

which is double the amount that was bid for.

As a businessman, I am confused by the idea that someone would bid for £1.1 million when the estimated cost was £2 million. There are two serious questions to be asked when we receive answers such as that. First, is £1 million enough money to do the job? That is probably the most important question. Secondly, are we getting value for money?

Alex Neil: Let me give you a three-pronged reply to your question. First, the baseline budget for SMC for the financial year that we are now in is

£1.1 million. Secondly, on top of that, we are making available an additional £815,000 specifically to deal with the challenges of introducing the new policy on access to medicines. This year, SMC will have a total budget of £1.9 million available to it. Thirdly, since Professor Timoney made that statement, we have done much more detailed costing of ongoing resources that will be required to administer the SMC. Professor Timoney had overestimated many of the associated costs.

The SMC has a baseline budget of £1.1 million and will receive an additional £815,000 this year specifically to deal with the challenges of introducing the new medicines policy. That additional money will allow it to employ an additional 16 people this year, as part of its resourcing. I hope that, to all intents and purposes, we have put the issue to bed and made available to the SMC the resources that it needs to do the job that we have tasked it with.

Gil Paterson: It seems that there is a coming together of the figures when the two sums are added together.

Alex Neil: Yes.

Gil Paterson: My other question was whether we are getting value for money. It is a serious question.

Alex Neil: Absolutely.

Gil Paterson: If an organisation such as the SMC bid for £1.1 million and then all of a sudden, within a few lines of conversation, what is needed goes up to £2 million—and the Government has now conceded that more resources are needed—that must be explained.

Alex Neil: To be honest, that can sometimes happen in the to-ing and fro-ing. I am a politician and am surrounded by officials; earlier you heard from two officials from NHS Lanarkshire. Professor Timoney is a medic, not a politician, so perhaps she did a bit of to-ing and fro-ing under questioning, but the absolute position, which is accepted by the SMC, is that we are resourcing it to the tune of £1.9 million this year. We believe that that is value for money, because we all agree that a key part of delivering a health service that is fit for purpose in the 21st century is an access-to-medicines policy that ensures that the people who would benefit from new drugs can get them, provided that the drugs do the job that they say they will do on the tin. I also think that improving the transparency and efficiency of the SMC and giving it a slightly wider task than it had before will provide value for money.

We obviously keep such issues under review; we will review the SMC after the first year of its being up and running under its new guise.

Gil Paterson: The committee has heard that our system is world renowned and is admired and copied in other places because it is cost-effective. You pre-empted my other question, but perhaps you could say a little more. You said that the SMC and the Government are satisfied that the resources are at the right level. Are you saying that that will do the job correctly?

Alex Neil: We are satisfied that the resource will enable the SMC to do the job. If the SMC were to come back to us at some future date and say that it does not need as much or that it needs more, we would consider that, but we have looked at the job that needs to be done, the resources that are required to do it and the cost of those resources, and we are pretty satisfied that £1.9 million for this year is right.

When it comes to spreading the patient safety programme and the SMC to other parts of the world, I sometimes think that we should formally franchise them and earn a bit of revenue for the taxpayer.

The Convener: You have just suggested that the woman who heads the SMC and gave it that reputation was intimidated by my questions in committee. That is hardly a good recipe for the future. Can you confirm that there are additional moneys of £850,000 on top of the budget to deal with the consequences of the review?

Alex Neil: It is £815,000, convener—not £850,000.

The Convener: Is it £815,000 on top of the £1.1 million?

Alex Neil: Yes.

The Convener: It might have been a slip of the tongue, but we gave Professor Timoney three figures and she said that it would cost nearer £2 million to do the job properly, and that she bid for much more than £815,000. Let us leave that aside, however. The point of my question is whether the funding will allow that body to deliver by May.

Alex Neil: Absolutely—it will allow that.

The Convener: Have you had that confirmed?

Alex Neil: I am convinced that that is sufficient resource—

The Convener: No—there has been a delay. Has the money been allocated? When does recruitment start? The SMC has a timetable to deliver on by next month.

Kathryn Fergusson: Additional funding was requested from 2014-15 onwards, so that funding has been made available to HIS in the current financial year.

The Convener: When did it get confirmation that that money would be in its budget?

Kathryn Fergusson: A figure of around £605,000 was confirmed to Healthcare Improvement Scotland in February, and the balance to take it up to £815,000 was confirmed in early March. That money should buy us a number of additional staff, as the cabinet secretary has said, as well as the expenses of the pay system and meeting in public.

You are quite right to say that the SMC bid for about £1.1 million. As work was done on the figures with Healthcare Improvement Scotland, some costs—for example, the costs of meeting in public—turned out to be significantly less than had been anticipated.

Other costs, which were included in the first version of the business case that came to us, were not required, having been considered alongside some other HIS funding. Some costs did not directly support what we are trying to do, so the Scottish Government did not support them. Those were not related to staffing costs, however. That is the reason for the difference.

To pick up on the point that the convener made, the SMC is now taking submissions that will come under the new system; right now, pharmaceutical companies are putting through submissions that will come under the new system.

12:30

The Convener: So, the SMC will deliver in May. It is not being held back; SMC will have sufficient funds to do that.

Kathryn Fergusson: The SMC is absolutely not being held back.

The Convener: The judgment of the outcome will show whether the process is right.

Kathryn Fergusson: Exactly. That applies to the process that has been outlined to the committee. Decisions should be taken in the autumn by the SMC under the new process.

The Convener: In the autumn?

Kathryn Fergusson: That is when there will be decisions coming out at the end of the process.

Alex Neil: That is how long decisions take.

Jackson Carlaw: I have a couple of questions. You were kind enough, cabinet secretary, to provide that the rare conditions medicines fund should have its resources made available to support any interim arrangements. Were those funds drawn upon?

Alex Neil: No. I think that I am right in saying that we did not—

Kathryn Fergusson: We are at the end of the financial year, so we do not have all the final figures, but we expect the budgeted amount for the rare conditions medicines fund to have been fully utilised in this financial year. The boards' directors of finance are dealing with that, given the various other pressures on boards.

Jackson Carlaw: My other question is about continuing flexibility. You have spoken about the patient and clinician engagement—PACE—meeting. I would not expect us to comment on any particular drug, although there is one that I am interested in: ipilimumab, which I believe will be the first drug for first point of use to go through the PACE system. It was previously approved for secondary use.

You will, I hope, consider the way in which drugs that present through the new process are affected by whatever new regulatory or structural framework is in place in order to ensure that nothing in that unintentionally proves to be prejudicial at the other end. I am looking for assurance that it is your intention not to allow the new process and its structures to become set in stone—simply because we have such a process—if it turns out that they function in a way that is contrary to your original intention, or if they themselves become an obstacle to our correcting the very thing that we are trying to correct.

Alex Neil: We have said from the beginning that we will review the process after a year on whether it is achieving its objectives. The answer to your question is yes.

The Convener: If there are no further questions, I thank the cabinet secretary.

Alex Neil: It has been a pleasure.

The Convener: I am sorry. I see that Rhoda Grant has a question. I got mixed up there: I have recess lag or something. I recall that you spoke earlier, although it was on a different subject. I apologise.

Rhoda Grant: I had one supplementary, but I now have two on different subjects.

My understanding was that the SMC's concerns about funding related to when it would be confirmed. Knowing when it would be available would allow the SMC to recruit. Can you confirm whether it has now recruited the staff that it requires for May?

Kathryn Fergusson: The recruitment programme is on-going. Some recruitment was done in the last financial year with additional support from Healthcare Improvement Scotland. Many of the jobs are highly skilled specialist jobs, so there are not a huge number of candidates, but the SMC, through Healthcare Improvement

Scotland, has a recruitment plan drawn up, and it is being implemented.

Rhoda Grant: You do not envisage a problem with recruitment.

Kathryn Fergusson: Nothing has been drawn to my attention to suggest that the SMC will not be able to deliver on what we have asked it to do.

Rhoda Grant: I return now to the transitional IPTR arrangements. You said, cabinet secretary, that you had spoken to representatives of NHS Greater Glasgow and Clyde to confirm that it was acting within the spirit of what the Scottish Government required.

Alex Neil: We have spoken to representatives through my officials. I did not speak to them directly.

Rhoda Grant: Okay. Have you issued new guidance to the board on the back of that, to ensure that it is clear about—

Alex Neil: We have followed the guidance that we got from the committee's report, which is to make the system as flexible as possible. Rather than say that we will have a flexible system, but then to issue two, three or four 20-page lists of things that boards can and cannot do, we are giving them the flexibility—at least for the first year—to see how it all works. If, at the end of that period, we think that we need more prescription, we will consider that. We wish to minimise centralised prescription with many tight terms and conditions.

Rhoda Grant: Could that be the issue? Is it the case that, because the guidance is not clear enough, boards are interpreting it differently?

Alex Neil: The overall guidance is clear. The core issue is that, if an application is made under the peer approved clinical system and the medics agree that the drug would benefit the patient, the patient should get the drug. "Benefit" must be over a reasonable period of time. Within that system, boards are free to do what they want.

Rhoda Grant: So, no new guidance has been issued.

Alex Neil: I do not plan to issue more detailed guidance at this stage but—in answer to the earlier question from Jackson Carlaw—we will keep the situation under review, and we will have a more formal review at the end of the year. If we feel that more detailed guidance is required, we will consider that. In its report, the committee encouraged maximum flexibility; that is what I intend to pursue.

The Convener: I am sorry about this, but I seek further clarity. I think that Rhoda Grant is talking about the transitional arrangements. I am sure that something came across about a two-month review.

Alex Neil: I am sorry. I thought that you were talking about the new PACS. I apologise. Kathryn Fergusson will give an update.

Kathryn Fergusson: On the point that was made earlier, it is important that from next month we should not be here talking any more about IPTR criteria, because we will be in a new world, where we will have an SMC with a different framework and a PAC system that seeks to fill gaps. The convener is absolutely right that the transitional period is important. However, we are not losing sight of what we are all trying to achieve. It is difficult to get there.

The Convener: You will give us an update on that.

Kathryn Fergusson: Yes—of course.

The Convener: Good.

Alex Neil: I will add one comment. As I said, we will review the situation after a year, and we will monitor it. One thing that I will do by way of monitoring is to ensure that the new system is not being abused by the drug companies. In particular, I want to ensure that they do not use the new PAC system to try and circumvent the SMC process. We are not prepared to allow that to happen.

Richard Lyle: I welcome your earlier comment about there being no postcode lottery and the commitment to patients. I take the point that Bob Doris ably made regarding NHS Greater Glasgow and Clyde, which is basically saying that the situation is due to the Scottish Government guidance being open to interpretation. I just love officials who try to find ways round new policies; perhaps they should be lawyers—although I mean no disrespect to lawyers.

Do the cabinet secretary and the Scottish Government believe that, with the new system, Scotland will be at the forefront of supplying end-of-life orphan and ultra-orphan drugs to the people who require them?

Alex Neil: Yes.

In relation to Glasgow, the only interpretation that matters is the Government's interpretation. Our interpretation is the policy that boards should be pursuing, and I expect NHS Greater Glasgow and Clyde, along with every other health board, to pursue it.

The Convener: You will have the committee's support in that.

Alex Neil: Thank you very much indeed, convener.

The Convener: I thank the cabinet secretary and his colleagues very much for their evidence and their patience.

Meeting closed at 12:38.

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