OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 15 May 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 15 May 2018

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HEALTH AND SPORT COMMITTEE
16th Meeting 2018, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Ash Denham (Edinburgh Eastern) (SNP)

COMMITTEE MEMBERS

*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Kate Forbes (Skye, Lochaber and Badenoch) (SNP)
*Emma Harper (South Scotland) (SNP)
*Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*David Stewart (Highlands and Islands) (Lab)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Simon Bokor-Ingram (NHS Shetland)
John Burns (NHS Ayrshire and Arran)
Chris Anne Campbell (NHS Western Isles)
Dr Martin Cheyne (NHS Ayrshire and Arran)
Neil Galbraith (NHS Western Isles)
Ian Kinniburgh (NHS Orkney)
Derek Lindsay (NHS Ayrshire and Arran)
Gerry O'Brien (NHS Orkney)
Ralph Roberts (NHS Shetland)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 15 May 2018

[The Convener opened the meeting at 10:00]

Subordinate Legislation

National Health Service Superannuation Scheme (Scotland) (Miscellaneous Amendments) (No 2) Regulations 2017 Amendment Regulations 2018 (SSI 2018/123)

National Health Service Pension Scheme (Scotland) (Additional Voluntary Contributions) Regulations 2018 (SSI 2018/124)

The Convener (Lewis Macdonald): Good morning and welcome to the 16th meeting in 2018 of the Health and Sport Committee.

I ask everyone to ensure that their mobile phones are off or on silent. Please do not use mobile devices for photography or to record proceedings.

The first item on our agenda is subordinate legislation. We have two instruments that are subject to negative procedure to consider. The first is the National Health Service Superannuation Scheme (Scotland) (Miscellaneous Amendments) (No 2) Regulations 2017 Amendment Regulations 2018.

The purpose of the instrument is to correct an error that was identified by the Delegated Powers and Law Reform Committee at its meeting on 16 January 2018.

No motion to annul the instrument has been lodged. The DPLR Committee has considered the amendment instrument and determined that it did not need to draw Parliament's attention to the instrument on any grounds that are within its remit.

There are no comments from members, so does the committee agree to make no recommendation on the instrument?

Members *indicated agreement.*

The Convener: That is agreed. Thank you.

The second instrument is the National Health Service Pension Scheme (Scotland) (Additional Voluntary Contributions) Regulations 2018. No motion to annul the instrument has been lodged. However, the DPLR Committee considered the instrument at its meeting on 8 May and agreed to draw Parliament's attention to the instrument on general reporting grounds in respect of four drafting errors.

The Scottish Government has indicated in correspondence that it intends to correct the errors at the next legislative opportunity, which will be in late summer this year.

Clearly it is disappointing that again, this consolidation instrument contains a number of minor errors, which requires that another instrument come to the committee at a later date. As members have no comments, does the committee agree to make no recommendation on the instrument?

Members *indicated agreement.*

The Convener: That is agreed. Thank you.

Scrutiny of NHS Boards (NHS Orkney, NHS Shetland and NHS Western Isles)

10:02

The Convener: The second item on our agenda is an evidence session with representatives of NHS Orkney, NHS Shetland and NHS Western Isles, as part of our programme of scrutiny of national health service boards. I am pleased to welcome to the committee Ian Kinniburgh, who is the chair of both the boards of NHS Orkney and NHS Shetland; Gerry O'Brien, who is the interim chief executive of NHS Orkney; Ralph Roberts, who is the chief executive of NHS Shetland; Simon Bokor-Ingram, who is the director of community health and social care and integration joint board chief officer at NHS Shetland; Neil Galbraith, who is the chair of NHS Western Isles; and Chris Anne Campbell, who is the nurse director and chief operating officer of NHS Western Isles. I welcome you all.

I start by asking Ian Kinniburgh to clarify the situation relating to the permanent position of chief executive at NHS Orkney. It would be helpful if you could comment on the current situation and future plans.

Ian Kinniburgh (NHS Orkney): The current position is that we are making arrangements to advertise for the permanent substantive post of chief executive of NHS Orkney. I hope that the arrangements will be put in place fairly soon in order to allow us to move forward with a degree of certainty, both for the board and for the individuals concerned.

The Convener: Thank you very much. David Stewart will ask the first set of questions.

David Stewart (Highlands and Islands) (Lab): Good morning. I welcome you all and am delighted to see you all here to discuss your boards. I want to kick off by talking about geographic challenges, on which you will all be experts. I am sure that the issue exercises you all daily.

Clearly, from the political side, there have historically been political devices that have helped—the air discount scheme, the road equivalent tariff scheme and structural funds, which have been focused on gross domestic product and population. If you want wider examples of what other countries have done, Japan's Remote Islands Development Act of the 1950s was an early example of providing help for islands.

Will the representatives of each of the boards describe how difficult the daily challenge is of providing services in-house, and of having to send people to other board areas? As a regional member, I have constituents who have had issues with patient travel, which I have raised with NHS Western Isles. I will perhaps talk about that later, but to kick off, will you talk about how you manage the geographic challenges day to day?

Ralph Roberts (NHS Shetland): That is probably the most important question for us. For me, when we talk about performance in the islands' context, we are often talking about sustainability of services, as opposed to relative performance. We are either delivering a service, in which case we will be meeting the targets, or we are significantly challenged in delivering it, and might therefore be significantly distant from meeting a performance target. That plays out in a number of issues, including recruitment and retention of staff and patient pathways.

As an island health board, we have to collaborate internally within the islands and within the region. For NHS Shetland, that is with NHS Grampian, which is where most of our patients go when they go off island. Over a number of years, and particularly in the past year, we have had some success in understanding how we can support more patients to come back to Shetland, and how we can manage their pathway so that as much of their care as possible is provided locally.

Neil Galbraith (NHS Western Isles): It might be useful to point out that there is a vast difference in the realities of the islands. Orkney and Shetland are in the north—the north-east—and the Western Isles are not only in the north, but are by definition in the west. Our communications are therefore with the northern region and with Glasgow. For example, many of our Barra patients go straight to Glasgow rather than being brought up to Stornoway. We face the same internal challenges, however, in all the islands. We deal with a string of islands, in which we try to ensure that the national health service gives a quality output, no matter where people live.

As David Stewart mentioned, we have to send people to the mainland, whether that is to the north or the west, and we have to consider the costs that are involved in that. The issue is not so much the cost of patient travel as it is the cost of escort. In the Western Isles, that is a matter of debate at the moment, because we are now applying the existing policy and rules as they should be applied—which is, of course, producing a number of complaints. Irrespective of that, people who are under 16 will always have an escort.

As Ralph Roberts's board is, NHS Western Isles is moving as far as we can in the direction of providing more services in-house rather than sending people to the mainland. Equally,

telemedicine and telehealth are coming to our aid. We see no real reason why a recall to a consultant in Glasgow for a 10-minute appointment cannot be handled over the phone—that is the simple approach—or through telemedicine.

We are seeking to make savings, particularly on patient transport, which I am happy to talk about in detail. However, the cost of that is not about the patient, but about the escort.

Gerry O'Brien (NHS Orkney): I will not reiterate what Ralph Roberts said. Another factor is that as well as the relationship with the Scottish mainland, there is an interisland relationship. Orkney has 18 inhabited islands, so we continually face the challenge of providing services not only on Mainland—which is principally through the Balfour hospital and five independent general practitioner practices, but across the range of our isles. We must actively support the GPs and populations on the other isles.

Our principal link is with NHS Grampian in Aberdeen; we have a very good relationship with it. We often ask people to travel from North Ronaldsay or Westray, who first have to travel to Kirkwall before they can travel on to Aberdeen. There are particular challenges across all the island groups with services out of hours or in the dark hours of the day. We face particular challenges in trying to provide services 24/7.

As Ralph Roberts mentioned, there are recruitment and retention issues, but when we have skilled practitioners on the island there is the challenge of keeping them skilled and not allowing their skills to atrophy because of the volume of work. That is a continual challenge that we face.

Ian Kinniburgh: It is worth adding that the three island groups are very different in how they are laid out geographically. When I first moved from Shetland to Orkney, I wondered why some of the solutions that we had put in place in Shetland did not appear to work so well in Orkney. That was because the communication links and the physical transport links between the islands vary. The Western Isles are different from Shetland, and different again from Orkney. We are all island boards, but we have our own individual internal challenges around communication and transport.

David Stewart: That is helpful. I will ask about the hardware that is available across Scotland. Some hardware, such as PET—positron emission tomography—scanners, are used only in much larger boards, which is understandable. You will not have the figures in your heads, but could you write to the committee with the number of patients who go each year to the other mainland—to Glasgow, Aberdeen or Edinburgh, where scanning can be provided? My understanding is that PET scanning provides positive and productive images that can be helpful for diagnosis, so clearly you would want that. Unless I am badly informed, I think that it must be difficult for your boards to provide that. There may be other types of scanners that you would like to provide: I have had discussions with NHS Western Isles about that.

I suppose that that is one of the known knowns. There will always be cases for which very expensive equipment is needed and you have to send patients on. There is cheaper equipment that you can provide and, I presume, you are able to speak kindly to other boards in your region to ensure that consultants are visiting the Western Isles, Orkney and Shetland, rather than being based solely in Inverness and Aberdeen. I have had some discussions about the matter with other boards, so I am interested to hear your views.

Simon Bokor-Ingram (NHS Shetland): There is a level of expertise that staff need to use such equipment, and expertise is also required for its maintenance. Although it would be nice to have equipment at the high-quality end, there is obviously a human angle to that, in terms of our being able to staff and sustain it. The point about low volume has already been made. We would have to sustain that level of expertise in a group of staff who might perform very few scans of particular areas of the body that require expertise in how to position the patient to get the best images. That is probably the key factor in terms of skills retention and skills decay, in respect of operating such equipment in the first place.

Chris Anne Campbell (NHS Western Isles): We have been looking at purchasing a magnetic resonance imaging—MRI—scanner, because we established that we could, if we had one, save about £250,000 a year on patient travel alone. However, when we looked into purchasing one at a cost of nearly £1 million, we realised that we would actually save less than we would spend if we just carried on sending patients to the mainland. Those are early figures, however.

Neil Galbraith: The point at issue is that most of our hospitals would be classified as rural general hospitals—although the one in Stornoway is rural general plus, because it does a few more things than a normal rural general hospital would do. With the population that we have, buying such equipment would simply not make economic sense. Apart from how expensive equipment can be, we would need to recruit workers who understand the equipment, understand the data that it produces and make accurate diagnoses and correct decisions. We rely on other health authorities, and we have service level agreements with them. We depend on NHS Greater Glasgow and Clyde, for example, and we frequently send patients to the Golden Jubilee national hospital.

We have worked together with the north for about 15 years now, and we are now moving into a much more formal regional approach. We are no strangers to that way of working. As small boards, we have always been dependent on working with the larger boards, and they have in all cases been very supportive.

Ralph Roberts: I absolutely agree. It is about making a judgment on the balance of quality, access and staffing, as is the case with all our services.

We now have—I think that Orkney does, as well—a visiting dual-energy X-ray absorptiometry scanner that comes up in a mobile van a couple of times a year. There are different solutions for different hardware, depending on the detail. We considered that approach for MRI, but we do not think that it would work, given the practicalities of shipping an MRI scanner, even though mobile MRIs go to other places.

10:15

David Stewart: I will move on to the thornier subject of funding. As you know, the NHS Scotland resource allocation committee's formula takes rurality into account. I looked at the Audit Scotland report for 2017 and I could see the variations as far as the various island boards are concerned. Does that formula work for you?

I thought that that question would attract some interest. [*Laughter*.]

Ian Kinniburgh: I would say yes and no. In general, the formula seeks to address the situation in the islands, but the small scale of our boards and the fixed costs that are associated with their establishment and operation creates additional pressure. There is still a case to be made on extreme rurality. In Orkney, for example, we successfully made a case that there are additional costs associated with the particular model of primary care that is operated. There is potential for a similar, although not identical, case to be made around the model that is applied in Shetland. Those are, if you like, the subtle differences that are not fully taken into account by NRAC. Having said that, I also think that it is entirely up to us to make that case and to see whether we can get support for it.

Neil Galbraith: There is actually not much of a problem with NRAC; it is a very fair way of distributing money. Unfortunately, however, it starts with a quantum that has to be divided up to suit all the various boards, and we always end up facing the fact that there is insufficient money for the year. In NHS Western Isles's case, we have to make £3 million of savings this year to make sure that we come in on budget.

We have successfully managed to do that for 10 years in a row, and I expect that we will, yet again, attempt to come in on budget, but it is a challenge at all times. There is a constant, almost weekly, check on how budgets are functioning. I know for certain that my acting director of finance has quarter-of-an-hour systems running in which constant reports pour in explaining exactly where we are on finance.

One cannot fault the NRAC formula, but we would not object to seeing the quantum that it works with being increased.

Gerry O'Brien: Three years ago, when I was the director of finance at NHS Orkney, I worked closely with the NRAC technical group on looking at the constituent elements of the NRAC formula, and we successfully made the argument for subdividing the remote and rural aspect into what we might call the even more remote data zones. We used as a proxy for that places that are entitled to the distant islands allowance, because we argue strongly that the isles are different from the more remote and rural areas of the mainland. At that time, all three island boards picked up well on the NRAC formula.

Ian Kinniburgh made a valid point. To be fair, the subject has been discussed extensively at the technical committee. There is a de minimis level of costs for the things that an effectively functioning health board must have, including what is needed to support the pillars of its governance work. However—to pick up on Ian's point—I agree that we have got NRAC to a point at which it reflects boards' remote and rural or island nature. I do not think that we could sit here and disagree with the formula as it stands today.

David Stewart: I will move on to my last question, at this stage. Clearly, the "Our islands—our future" campaign is very important, and all parties have been discussing what more we need to do to support the islands.

A couple of years ago, I met at the Convention of Scottish Local Authorities the three previous conveners of the respective local authorities—I think that they have all moved on since then—and they were very keen on having a single public service operator for the islands. At one level, that would give you greater scale. It would not, perhaps, give you more health muscle, but it might give you more synergies in finance and other issues. Do your boards have a position on that concept?

Neil Galbraith: We are all at various stages. For example, you will be well aware that most of the discussions on single islands authorities have taken place in the context of local government: there has been no involvement of, or discussion

with, any of the health boards prior to decisions being made.

Western Isles Council has produced a report that puts forward a number of possible options for the future, one of which is to dispense with not only the integration joint boards but the health boards, and to run the system as a subset of the council. You can see from one angle that that makes a degree of sense. It would certainly be useful if we could achieve savings from any such move, but the key point will always have to be that what is done guarantees patient safety and ensures that quality is not diminished in any way.

NHS Western Isles's board has not yet met to discuss the council's proposition. Part and parcel of what the programme for government included was that the Scottish Government would consider any proposal, but it rests entirely with the council to promote such a proposal, which it has to do with a set of caveats, one of which is that it must involve the people who have an interest. From the point of view of the Western Isles, we hope that, at some point, the council will consult us.

Ian Kinniburgh: I have a slightly different perspective. The programme for government clearly gave local authorities the opportunity to explore having a single public authority, and it set out a list of caveats that must be adhered to if we are to successfully progress a proposition.

The approaches of the three island councils have been different. In Orkney, the council is proactively pursuing that agenda. We are in discussions with the council, and we are very mindful that we need to demonstrate benefits to the community and improved outcomes, and that we need to protect the staff and the NHS. In Shetland, the council has yet to really form a position; therefore, the discussion with the board is in an entirely different place. Clearly, in the Western Isles, another approach is being taken by the local authority. There is a mixed bag.

Ralph Roberts: I echo what others have said. It is about doing it together, working through the potential implications and focusing on whether what might happen would make a difference to the outcomes that we deliver for the community. It is not a theoretical question about whether it is a good thing to have a single organisation; it is about what that would mean in terms of outcomes. We would need to do that work, understand the benefits and risks and accept that, in an islands context, we are intimately integrated in the community.

With regard to health and social care integration, our primary and community services are closely linked with council and other services, but our acute services are linked to mainland services, so anything that we do on the islands must acknowledge that we work both ways. Our clinicians would take different views, depending on where they sit.

We would also need to be very mindful that one of our biggest challenges is recruitment. We would need to understand what our potentially being seen to be outside the NHS or having a different type of structure might mean for recruitment of staff coming from the mainland to Shetland, and for their long-term careers. I have no doubt that there are ways of managing that, but we would have to be careful to get that right, or we could have unforeseen consequences.

We have to explore the issue and understand the benefits, as well as being very aware of the potential implications.

Kate Forbes (Skye, Lochaber and Badenoch) (SNP): How do you ensure that you have the right skills mix of generalists and specialists so that as many people as possible are treated locally, in their communities, including for out-of-hours care?

Chris Anne Campbell: In the out-of-hours service, we have community unscheduled care nurses, who are trained almost to advanced nurse practitioner level. We will train them further using the ANP training funding that is coming later this year.

In the main hospital, we have moved to a model with no doctors present. It is run by clinical support nurses, who are advanced nurse practitioners. Since we reduced the number of junior doctors on night shift, the number of calls going out to consultants has reduced.

We are quite advanced with maintaining skills in the hospital at night, and we have also made a lot of progress during the day. The nursing staff in the acute assessment unit are not relying completely on consultant or junior medical staff, and we have extended scope practitioners in the accident and emergency department, who are also advanced nurse practitioners. We develop them over a period of five years, bringing them from band 5, at general level, through band 6 and into band 7, so we have some succession planning in place.

Simon Bokor-Ingram: I will describe it in a slightly different way. The picture is constantly evolving. We have to peel back the layers and ask what we actually need in order to meet need—what the core components are that we need in order to deliver the particular functions that will make sure that people are safe and looked after through a high-quality service. What Chris Anne Campbell described is absolutely right. We need that constant look at what we require to deliver the service, and at who else can deliver it—at the particular skill sets that are needed, because the traditional way of delivering services is not sustainable.

Talking from a Shetland perspective for a moment, we have for some time had particular pressures around recruiting general practitioners. That seems to be easing a bit, but we have been looking at what else we can put in place to meet need. There is, for instance, a very successful model using advanced nurse practitioners, and the opportunities offered by health and social care integration are a key component. That is about not only statutory service providers, but what the third sector can provide that might traditionally have been provided by statutory services. It is about taking a root-and-branch look at what we need and what the core components are for meeting need across the community.

Gerry O'Brien: I agree 100 per cent with what Chris Anne Campbell and Simon Bokor-Ingram said. Fundamentally, we all start from the same place, which is an assessment of the staffing levels and mix that we need to meet our particular circumstances, whether that be in our acute, mental health or out-of-hours services. Then we have to add the dimension of the geographical challenge, particularly when it comes to the more specialist posts that we may need for patients that we may well have to transport off island using the Scottish specialist transport and retrieval service.

It is a fallacy to say that all the sickest people are taken off the island. That may be true, eventually, but we often have to look after very ill people on the island, needing to stabilise and intubate them for perhaps 12 or 14 hours while we are waiting for the helicopter or the fixed-wing plane to get to the island so that the retrieval service can take them away, and we need to provide for that.

When we look for consultant medical staff, we look for a broad range of experience. We need the specialist generalist that is being developed now—that odd animal that can deal with all ages, children and adults, and can remain calm in an emergency. A good friend is working with us—an anaesthetist with whom I used to work in NHS Borders 20 years ago. He is a very experienced anaesthetist, but even he said that the first time that he stood there waiting for the ambulance to come through the door, he did not know what was turning up and he could not dial whatever number to call the orthopaedic surgeon, paediatrician or whoever was needed.

We have to think about those dimensions. We start in the same place as all our territorial board colleagues with an assessment of our need, and then we try to put the island dimension on that.

It is slightly different when we get into the isles, where we might have GPs and advanced nurse practitioners. We look to upskill them in basic and advanced life support. Those are probably minimum requirements because we are staffing in the isles not for the in-hours primary care activity but for emergencies that might happen out of hours. They need to be competent to deal with those. That brings with it the challenges of recruitment, retention and skills atrophy about which we have spoken.

10:30

Kate Forbes: Is your focus at the moment on trying to treat people as locally as possible, albeit that there is sometimes a need to transport them off the island?

Looking to the future, how are you preparing for the demographic challenge of an ageing population and the potential impact of Brexit on the workforce in light of the reliance on European nationals as healthcare professionals?

Those are small questions!

Gerry O'Brien: We will respond in reverse order this time.

Those are two significant challenges. The demographics are a challenge from two perspectives. The first is the ageing population that we serve and the challenges of multiple comorbidities that come along with that, which we already see lots of. However, in line with that, we also have an ageing workforce. About 32 or 33 per cent of our workforce is aged over 50 and, within the next two years, about 20 per cent of them could exercise their option to retire.

We are always mindful of that for our workforce planning. We ask what skills we need. In the islands at the moment, we have particular challenges in old-age psychiatry. We would like to engage our own old-age psychiatrist. We might not have 100 per cent need for such a post today, but we will in three, four or five years and we are always mindful of the recruitment timeline that might be involved.

We are also always mindful of Brexit. On Orkney, we do not see a direct correlation with the Brexit decision at the moment but, when I speak to colleagues in the territorial boards, particularly in medical education, we see that it might well be having an impact on the number of trainees who are coming through the system.

For the past couple of years, we have had a big push through our director of medical education, whom we share with NHS Highland, to encourage undergraduate level trainees to come to Orkney. They are coming and having a great time professionally and personally. They are really enjoying it and we are getting really positive feedback, so we hope that we will get some of them to come back when they are qualified. We recognise that, in some of our areas, we attract people at either end of their career—those who

are just kicking off or those who have had an active career and are now looking to pass on some of their professional skills.

We take all those factors into account. The demographics of our population and our workforce are definitely prime in our thinking. We are not seeing the impact from Brexit that some of my territorial board colleagues see.

Neil Galbraith: To emphasise the demographics, NHS Western Isles is in the worst position of the lot because we have a proportionally much more aged and ageing population. That is allied to the fact that we have the lowest proportion of youngsters entering employment. Therefore, we will be hit by a double whammy.

In collaboration with the University of the Highlands and Islands, we have tried to promote a number of courses. Indeed, the university needs no encouragement to find other courses. It has taken over nurse education and we have a provision for that in the Western Isles.

Equally, we are now represented at careers conventions in schools to make it clear that there are more jobs in the health service than those that tend to appear. For example, I work with volunteers quite a bit and we have a fair number of youngsters from schools who happily volunteer to come to the hospitals to do a bit of support work. I have to be honest and say that the girls almost always gravitate towards the maternity ward as their main interest in volunteering. However, such involvement will, we hope, spark an interest and help people to realise that there is a huge range of jobs available in the health service.

As far as Brexit is concerned, we are pretty much the same. In fact, seven—I think—of our consultants are Polish, so we have to be concerned about whether they will stay, depending on the Brexit decision, and what the arrangements will be. Like everybody else, we will have to be fleet of foot, in so far as we can be, when it gets to that stage.

Chris Anne Campbell: We certainly need to assess that aspect quite closely. Four of our anaesthetists are Polish, and if they all left at once we would be in significant trouble.

Ralph Roberts: I will start with Brexit. The point about the mix of our consultant staff is well made; it reflects the fact that, over time, the United Kingdom has not trained doctors to work in rural areas. Looking at where we recruit from, we find that people from elsewhere in the world are probably a better fit because of the breadth of their training. We have just recruited for anaesthetic posts, and we have had responses from locum anaesthetic consultants who work in India. They have a very broad skill set, which fits quite well with our needs.

As a board, one of our responsibilities is to ensure that, as a system, we in the UK become better at looking at that issue. We were part of the recent General Medical Council visit to Scotland, and we made the point to the GMC that it needs to develop its training in future in order to get that breadth right. There are very small places, such as the islands, that have to fill a particular niche, and it is really important that we consider those issues.

Another important issue concerns the pipeline. We need to encourage our population to look at careers in health. All the evidence from around the world tells us that, if someone comes from a rural area, they are much more likely to go back and work there, so we have been pushing quite hard on that. Quite a lot of work has been done to support kids from deprived areas—quite rightly—to get into medical school. I would certainly look for that support to be rolled out into rural areas, where it would be very beneficial.

The only other point that I will make about demographics is that it is where community planning comes in. We need to work with our community planning partners to ensure that the population mix in the islands is as vibrant and economically active as it can be. One of the main priorities in the Shetland community plan is to consider how we ensure that the population mix is right.

Simon Bokor-Ingram: I have one quick point to add. We should not forget that the same applies to social care, which underpins an awful lot of care in the community—without it, the need for care would swamp the NHS. We have not only an ageing population but an ageing workforce. In addition, the depopulation of some of our more remote areas in Shetland is clearly having an impact, as it makes it really difficult to recruit and retain those staff who are so integral to keeping people in the community.

Kate Forbes: I have one last point, on the collaboration between NHS Western Isles and NHS Highland in trying to recruit professionals who have experience of rural areas and have the right skill set. Last week, the Scottish Government launched a pilot programme for midwifery. That is a great example—what other concrete examples are out there? Would you like to see joint working with UHI or colleges to ensure that trainees have the right mix of skills to meet your needs?

Chris Anne Campbell: To give one example, we face severe challenges in maintaining our laboratory services, and I would like UHI in particular to work closely with us to support those services. We are taking on medical laboratory assistants who will progress to become biomedical

scientists. We are supporting one assistant who is actually attending Ulster University, and we would like UHI to offer some of the courses that Ulster currently offers, because her travel time—four times a year—is significant. Anything at all on sharing laboratory services that could be provided as a means to support the local workforce would be excellent.

Neil Galbraith: In the past, in education, the colleges used to make specific provision to take students from the islands. They gave people a guarantee of entry as long as they met the necessary qualifications to be admitted.

A system that would guarantee entry for those living in the islands who met the qualification levels would help us greatly. For example, two of our doctors were born and raised in the Western Isles and have come back to work in the islands. It is the proof that moving from a city on the mainland does not come as a culture shock if you have come from a rural background in the first place. Frequently, we can recruit successfully but we cannot retain the staff, because after two years of the winds that blow on all the islands, people realise that the day that they came when the sun was shining is not the norm.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning and thank you for coming to see us today. I would like to focus on general practice and, in particular, on the response of your local practices to the GP contract. The contract has been received pretty well across the country, although committee members have been very effectively lobbied by rural GPs and groups representing them who have concerns about the contract and what might happen in phase 2 in three years' time.

Given the remoteness of your wards and their particular rural needs, the risk might be particularly acute for the areas that you represent. How has the GP contract been received locally and what work are you doing with the GPs to influence the next phase?

Neil Galbraith: The way in which you have posed the question is very helpful, because the concern is not so much about how phase 1 has been implemented but about the prospects for phase 2. It appears that those in rural areas are liable to be paid less than those in the central area because, for example, payment may move towards numbers of patients. I accept that there is a rationale for that.

I do not want to miss the chance to make the point that another part of phase 2 is that the health boards will take over responsibility for all the premises, which has a financial cost, which we would want to ensure was included.

However, to go back to the basic point of your question, currently, because of the guarantee that no one is losing any money, there is a general acceptance that the contract is, on balance, a better deal than has been the case. However, there is no guarantee about what will come out in phase 2, so there is concern. Overall, there is acceptance but also concern.

Ralph Roberts: As Neil Galbraith said, the most important part of the question is the impact of phase 2. In Shetland, although we do not yet know how it will play out, phase 1 of the contract will make very little difference other than in perception, because the income of most of our practices will be protected—assuming that it does not lead to people moving elsewhere because they think that that place might get additional money. However, the impact of phase 2 is important and we need to ensure that we influence that appropriately.

Two of our practices in Shetland are independently provided and the rest are provided as salaried practices, which means that the GP contract does not have the same direct implication.

Broadly, there are differences of opinion. Some of the practices have been quite exercised about some of the potential impacts of the contract, and others think that many of the underlying messages in the contract about the development of multidisciplinary teams, focusing the role of the GPs and having other members of the team doing other aspects of work, are absolutely the way in which primary care should go. The challenge for us is how to play that out. That is the work that we should be doing, linked into the memorandum of understanding around the primary care improvement plan. We should be sitting down with our GPs to see what it really means and how we are going to do it.

We also need to recognise that, even in somewhere like Shetland, we have different practices. We have a practice in Lerwick that has 7,000 people and is similar to a rural practice in any Scottish town that is a similar size to Lerwick—the fact that it is on an island does not make much difference at that level. We also have practices that serve a population of only 500 and those practices are completely different. Part of our job is to ensure that we apply the contract appropriately within the Shetland context.

Ian Kinniburgh: It is important that we engage with primary care and all our GPs to encourage them to be actively involved in the discussions and negotiations leading up to the implementation of phase 2. A lot of the issues at the moment are probably due to either lack of information or misinformation, so making that work more effectively might help us to iron out some of the potential pitfalls as the contract evolves.

10:45

There is another point that I would like to bring to your attention, and I guess that it applies to everything to do with remuneration. It is a point that we have made with the team working on the GP contract, and it concerns the impact of the minimum income standard study, which clearly demonstrates that the cost of living in remote and rural Scotland is significantly different from the cost of living in other places, particularly the central belt. In fact, in very remote parts of the islands, it can be 40 per cent higher. When we start talking about national contracts and national remuneration, we need to remember that the pound does not go as far in those areas, so individuals may be indirectly penalised because the cost of living in those remote locations is significantly higher.

Alex Cole-Hamilton: In the light of everything that you have all said, is there a concern about recruitment, given that there is an element of uncertainty about what phase 2 will look like? To that end, would you welcome clarity and certainty sooner rather than later, and will you be actively lobbying on the process for phase 2?

Ralph Roberts: We will certainly be lobbying. I have been asked to sit on the short-life working group on rural implementation of the primary care contract, and I am pleased to be part of that. That is an area where we will be looking at how the contract plays out in rural areas. We are continually focused on the recruitment issue. We have made some progress this year. At the beginning of the year, about 20 per cent of our GP posts were vacant. The situation has got slightly better, but we are still finding it very difficult to recruit to the very small practices where we are asking people to work 24/7 for long periods of time.

That will continue to be an issue, and I think that it is one of the aspects of phase 2 that we need to understand. The feedback that we would get from GPs is that the way in which the formula in phase 1 has played out around workload has not properly recognised the complexity of the job for a GP in a remote and rural area. Often, that is not about individual patients coming through the door but about a GP's ability to have colleagues immediately on site and the fact that they have to provide emergency services. One of the aspects that we must address as phase 2 develops is how we can properly recognise the workload of a rural GP.

Gerry O'Brien: That is 100 per cent the key point. To give you a bit of context, Orkney has six GP practices on the Orkney mainland, five of which are independent, and we have a sixth board-administered practice that covers our outer isles. There is an acceptance of the contract—I would say that "acceptance" is the correct word, rather than "embracing"—but our ambition and our aim through our implementation plan is how to define the role and responsibilities of a remote and rural GP, because the expectations and requirements are different, and they even differ across different parts of the island.

Our two practices that are based in Kirkwall will, from this time next year, be physically based in the new hospital facility, giving them ready access to facilities that GPs 11 or 12 miles away in the east or the west of Mainland will not have. Patients at our board-administered practice, which covers the outer isles, might need to take a ferry and then a bus journey—or, in the worst-case scenario, a ferry and then an ambulance journey—to get to hospital.

We need to look at how we develop the role of the GP, and that is something that we are definitely looking to do together. There is no other way we can do it. I have told my GP colleagues that I am keen to have an active conversation with them about how to develop those services. We have a new facility coming online in Kirkwall, and we are looking to get the maximum use out of it. The premises are not really an issue for us, because the health board already owns all the premises that the practices operate out of, but we are looking to extract every advantage that we can from the new contract.

We are probably in a similar situation in that, at the moment, we do not foresee GPs leaving because of a perception that there might be more money to be earned down south. Our GPs make a lifestyle choice, as do most people who move to the islands. To pick up on a point that has been made, some Orcadians have now come back to the islands as GPs.

It is more of a struggle for us to recruit at partner level. People might not want to take on the responsibilities of becoming a partner and might be happier being a salaried GP in an independent practice. We have seen that shift, which has put more of the management and senior partner burden on to one or two key individuals.

Neil Galbraith: The question was whether we are concerned, and the answer is that we are. As the committee well understands, it is difficult to recruit, but it is just as difficult to retain. People might decide after two or three years that the lifestyle is not for them—working for four days a week and surfing for two days a week might not be what they had planned. Therefore, we are concerned.

That is part of a more general concern. The committee will know about the plans for setting up centres of excellence. The nature of the jobs in those centres will be a very attractive proposition

for doctors and consultants, so we run the risk of losing people.

However, we need to make the efforts—as we do—to ensure that there is a welcome to new recruits. For example, when we are recruiting a consultant, who may be older but not completely old, we are usually recruiting not only the one doctor but a family. Therefore, there has to be the socio-economic background that encourages the spouse to work or promotes the children's education. That is a long way of saying that the close work that we do with the councils matters, because the councils have the same concerns and problems with recruitment and retention. Collaboration on that is extremely important.

Our concern will not go away. It will ease to some degree once we are certain about Brexit, and then we can focus on what will be possible within the political framework in which we will be operating.

Ian Kinniburgh: I am an eternal optimist. I see this as an opportunity to engage with GPs in a different way and to construct something for them that looks different. If we are successful in doing that, I hope that that will make jobs more attractive and give us the opportunity to compete. Putting GPs at the heart of what we do, working in the localities and doing things in a different way could be an exciting opportunity, so we need to engage with GPs and with people who are going through training, in order to highlight where the opportunities will arise and, potentially, how much better the job could be than it is at present.

Ralph Roberts: I should mention that I have the pleasure of chairing the Scottish rural medicine collaborative, which supports some of that work. There are three areas that we are particularly focused on. First, we need to think about how we market, or change the mood music around, working as a rural GP, because it can be a brilliant job. Secondly, how we do make the recruitment process as good as possible? Obviously, we have huge opportunities because of our locality but, in most cases, it is about the job. How do we ensure that people focus on what the job is? Thirdly, how do we ensure that people who work in relatively remote areas are supported and have networks of support? If people do not get isolated, we can improve retention.

The Convener: Telemedicine was mentioned in an answer to one of the earlier questions, so I will bring in Emma Harper.

Emma Harper (South Scotland) (SNP): Good morning, everybody. Panel members have talked about geographical challenges and telemedicine. Last week, we heard from NHS Greater Glasgow and Clyde about how orthopaedic clinics use remote access. I am aware that NHS Dumfries and Galloway, NHS Ayrshire and Arran and NHS Western Isles are using the mPower programme, which tries to keep people in their homes for longer. That is very important when we have health and social care challenges—it is not just about acute care; it is about keeping people in their homes for longer. I am interested to hear about mPower, which is funded by European Union money through the Interreg programme. Will that money be safe post-Brexit? That is a challenge. How do you measure whether telemedicine is effective? Do patients like it?

Neil Galbraith: I will start and then I will ask Chris Anne Campbell to rescue me. Under the programme, we are working first to repatriate as many of the services as we reasonably can. For example, until about five or six years ago, most of our orthopaedic cases had to go to the mainland, but we now operate in the Western Isles. We are at the stage now that our orthopaedic provision, which was largely hips and knees, has extended to wrists as well. We are able to make that provision locally and, because of the advance of technology, we are able to link up to specialists in other areas who can follow up on quite specific points and give advice if they are asked for it.

As far as we understand it, because of the transition period—however it is described—the money will continue to flow until that point. What happens after that is of course up to the Government—it depends on how it wishes to do things.

I emphasise the point that the islands and the remote areas in the mainland are obliged by necessity to come up with solutions that are driven by technology, which eventually will be what the other boards do as well. The healthcare collaboration that is going on at the moment is quite extensive. For example, we have a new instrument that will basically replace the stethoscope, with which the person can not only sound a chest, for example, but see inside the heart. That information can be streamed on the internet to specialists elsewhere, who can advise on the approach.

The positive nature of the internet is opening up a huge opportunity for us. We can work to use the good bits of the internet. Chris Anne Campbell may want to add to that.

Chris Anne Campbell: We have patients with long-term conditions, such as cardiac failure, chronic obstructive pulmonary disease and diabetes, who are being monitored from home using the Florence telehealth service. The patients can input all their own information, such as their blood sugar levels, on a daily basis. If a cardiac patient is at risk of deteriorating, for example, a cardiac failure nurse will communicate with them immediately and can attend them in their home

rather than bringing them into hospital. It is almost as though early warning systems are in place for those patients. It seems to work very well.

More recently, we have introduced a mobile echo scanner in the hospital. Now, our echo sonographer can view the images remotely when she is not there and can provide advice so that patients can be transferred early to Glasgow or treated locally. There are several things that are in progress at the moment.

Simon Bokor-Ingram: I will continue briefly—I do not want to major on the theme of acute services. For a number of years, we have been doing ear, nose and throat clinics from Shetland, linking in with the mainland through technology. We are starting to use the attend anywhere system of out-patient appointments that are carried out remotely, and that is working well. However, it is early days and early steps for some of these services. They also rely on having people at the other end. If the people on the other end are on the mainland, they need to buy into it as well to support Shetland with these initiatives.

To touch on the community aspects, at the moment in Shetland we have over 600 pieces of technology-enabled care equipment out in the community, supporting people to stay safe and be cared for in their own homes.

One of the huge limiting factors for our ability to do more to link people's own homes either to a hub in Shetland or to the Scottish mainland is the availability of adequate broadband width to support these pieces of technology. There is a lot more that we could do and want to do. We can see the opportunities, but we are being hampered at the moment by the poor broadband width that exists in many places in Shetland.

Some of the most difficult places to use any kind of technology-enabled care are our most remote and rural places, which are the very communities where we could use the technology to support people better, provide a better quality of life for those individuals and, in particular, remove the need to travel.

We have heard from the Western Isles. We are in a slightly different position in relation to what we are trialling and using. Suffice it to say, we are trying to be innovative. A lot of changes are being tested in various places in Scotland, which is fine. I welcome the new digital strategy, which will give us a common platform. Again, that is important, because we have a myriad of systems.

11:00

We need systems that are able to talk to one another and to share information, because that is a key component of being able to provide integrated care across health and social care. At the moment, we do not have some of the platforms available to allow that. There are solutions on the horizon, but we will need to have them quickly.

Ian Kinniburgh: It is worth saying that telemedicine and telehealth are positives for patients and the patient experience. The technology is also a good way of unlocking realistic savings, which we can think about how to reinvest in order to expand that work.

If memory serves me right, in 2016, we avoided about 600 patient journeys in Shetland, because we utilised telemedicine. In the following year, I think that the figure increased to 1,400. Each journey costs at least £300 in air fares alone, so there is a significant financial incentive to encourage island boards to work more effectively in that way.

Points have been made about the factors that limit good communication. Inadequate broadband, phone links and mobile connectivity limit our use of telemedicine. The culture is an issue, too. We need to get people working on the mainland to be willing to change how they work in order to support us in using the technology more. We are working hard to overcome that barrier. We are making progress, but there is more to do.

The Convener: I think that Sandra White has a brief supplementary on travel costs.

Sandra White (Glasgow Kelvin) (SNP): Thank you very much for your evidence. As someone who comes from the mainland, I have found it to be an education.

I want to ask about transport and patient escort costs. I know a bit about the issue, because a number of people from the islands access health services in Glasgow, and constituents of mine who have relatives in that position come to see me about it.

I am interested in what Ian Kinniburgh said about there being 600 fewer patient journeys because of the use of telemedicine. How much of an impact does transportation have on your budgets? Is it very negative, or is the situation getting better for everyone?

Neil Galbraith: Transportation has a massive effect on our systems. The Highlands and Islands patient travel scheme was originally centrally funded by the Government. Therefore, to an extent, there was never any disincentive to send patients or approve every single patient escort. Three or four years ago, that money was handed over to the local authorities to administer. In the past financial year, we spent more than £3 million on transport costs, of which at least 46 per cent to 48 per cent was for patient escorts.

In certain cases, escorts are, without a doubt, necessary; in other cases, if we are talking about a 10-minute follow-up meeting, as I have mentioned, a simple issue can be dealt with over the telephone with a consultant. That latter approach would bring about savings, which we are keen to make. I must emphasise that we are simply applying the policy—we have not invented or introduced anything new—but that has not stopped complaints beginning to mount.

Gerry O'Brien: Orkney does not spend as much as the Western Isles—we probably spend about £2.4 million to £2.5 million through the Highlands and Islands patient travel scheme. In total, we probably organise about 6,500 journeys a year, of which about 1,700 are for patient escorts, which is a significant number.

To return to Mr Stewart's earlier point, we put a computed tomography scanner on Islay three and a half years ago, which probably saved us £300,000 a year on travel backwards and forwards to NHS Grampian to use its service. We use the national picture archiving and communications system and the national reporting system, because Grampian reads the CT scans.

There is definitely an incentive to try to limit the journeys, which would result in a saving to us and would probably also be the best thing for the patient.

Ralph Roberts: To put the matter in context, our budget is about £47 million, and last year we spent about £2.7 million on patient travel. This year, I think that the final figure will be nearer to £2.1 million or £2.2 million. That is partly because of the success that we have had in treating more people locally, and partly because we were able to negotiate a different deal with Loganair.

One of the risks for us going forward is that, as those of you who are aware of the air service issues in Scotland will know, we had competition on the islands this year—between Loganair and Flybe—for the first time, but that has stopped, so we are dependent on a single provider, which is obviously a commercial provider. We will shortly get back into negotiating with it on next year's prices, and there is certainly a risk there for us that we will have to try to manage.

Obviously, the financial aspect is important, but ultimately we need to recognise that behind every pound that is spent is a patient who is having to make a journey, and in many cases an elderly patient with an elderly escort. It might be a 10-minute appointment, and it might take them 12 hours. We have to remember the patient behind the statistics.

Ian Kinniburgh: I want to go back to the early point about the geographical differences between the three islands. I suppose the successful negotiations with Loganair around patient travel were partly predicated on the fact that, in Shetland, we had a realistic opportunity to send all our patients by boat. That was not particularly attractive and the public let us know how unattractive the proposition was, but nevertheless it was a real alternative. I think that it helped to bring Loganair to the negotiating table, and therefore we were able to get a preferential deal from it.

That does not apply in the Orkney context, because we would need to have a daily boat to Aberdeen, which we do not have. We have two boats a week to Aberdeen. In Orkney, we would not be able to put that threat, if I can call it that, on the table to Loganair. I suppose we are really trying to negotiate with Loganair with a hand tied behind our back, if we are trying to get the same kind of beneficial deal that we have managed to achieve in Shetland. It is not that we do not want to share the good practice and roll it out. It is just that the commercial reality makes it challenging for us to do that.

Neil Galbraith: I want to add a gloss on the earlier question about cost, because I have a useful example. We moved from having one consultant orthopaedic surgeon to two, and the effect was immediate in terms of the number of people we were able to deal with in the Western Isles. There was a huge saving at that point. What we had not reckoned on was that, with two of them working—they are extremely successful and extremely experienced—it began to cost us a small fortune in ceramics and steel, because they began to use those things. We had not budgeted anything like sufficient money for that. What we saved on patient transport was instantly swallowed up in making sure that people were cared for and able to walk.

Ivan McKee (Glasgow Provan) (SNP): Good morning, panel. Your evidence so far has been very interesting. I want to follow up on the technology side and broaden it out a wee bit. I know that there are issues around financial challenges—I think that we will talk about those later—and some of your performance measures, although it is good to see that on many of them you are performing better than the Scottish average.

I want to delve into performance improvement to get a better understanding of how you go about that. How do you identify opportunities for savings and opportunities for performance improvement? How do you share best practice? Is there a structured process for that or is it just ad hoc? Do you just hope that good ideas will make themselves apparent or do you have a structured way of digging out actions that you need to take in order to continually improve performance?

Gerry O'Brien: Process improvement, whether it relates to cash or non-cash savings, has become a lot more structured for the entire service. That has certainly been the case in Orkney over the past couple of years. To go back to first principles, everything starts with the data to try to identify the opportunities. As with all such things, we usually start with considering the areas where we are an outlier: where we are spending more than the average or more than we would like to and where we are performing badly. There is then a process. Over the past couple of years, we have taken a lot of time to train lots of people in the specific skills that are required rather than just randomly say that, just because we are an outlier we are bad—as you will know, that is not always the case. It is about understanding the data over time.

We target areas. Our approach to clinical services is driven by the areas where we are an outlier. That generates our improvement plans, whether in dermatology, cardiology or ophthalmology. We go through much the same process in relation to financially driven efficiencies. I think that we would all accept that the days of the low-hanging fruit are well gone. How we identify such savings is one of the challenges that I am sure that we will discuss later, but there has to be a systematic review of the underlying data to tell us where we go on that.

In Orkney, we have adopted a methodology of strategy deployment matrices. Our ambition is that, by the end of this year, every department will have its own improvement plan in place, and we are already a good way there. Some of them already have plans in place whereas others will merely have identified, by the end of this financial year, the areas where they want to improve. As you might expect, the people who were keenest to be involved are those who are furthest ahead at the moment. We take a very structured approach to that. We identify the baseline, the changes that we would like to make and the expected changes that would come out of that. There are then lots of small-scale tests of change. We have applied that methodology to infection control and a series of clinical services.

I will not sit here and say that we are perfect, but we are trying to apply a structured approach. We have limited resource to look at the issue, so we try to target our experts on that. We very much try to take a training approach. We find that we get the best results when it is the staff who generate the ideas. They then feed in through the organisational structures to our senior management or leadership team, which I chair and which includes all the direct reports to me plus various other heads of department. We pull that together monthly. It is a fairly structured approach, rather than just saying, "Let's go through it."

Ralph Roberts: I echo everything that Gerry O'Brien has said. It is about using the data, focusing across the organisation and understanding where the issues are.

I will pick up on a number of areas where the islands are unique. One challenge relates to our ability to focus individual members of staff on improvement in the same way that some of the bigger boards do. We have staff who have to cover a range of areas. We try to use national programmes as much as possible. We sometimes feel that we are disadvantaged in doing that, because it is harder to get down to improvement events. Getting face-to-face contact can be an issue for us. It can sometimes be difficult just to release staff to go to events, because there might only be one or two members of staff in a team. We continue to work on that area.

On resources, a number of years ago, we set targets across the organisation and expected individual areas to deliver those. We tried to do that in a focused way, so we had differential targets depending on how we wanted to shift resource in the organisation. Increasingly, as we have done that and as areas have developed that work, we have been moving to a whole-board approach. We have just run a scenario-planning process in which we looked at the future model of service in the whole organisation. That will then allow us to drive efficiencies in individual areas, rather than say that everywhere needs to deliver. The low-hanging fruit, if you like to use that phrase, has gone. It is now about understanding the key areas of major redesign where we need to focus our efforts and resources.

11:15

Neil Galbraith: I am conscious that there are a few subquestions there, and I may not pick them all up.

Every year, all the executive directors set targets for themselves, all of which are aimed at improvement. They all start from the basis of the current situation and set out what they hope to achieve by the end of the year. At the end of the year, the chief executive reviews all that progress—we hope it is progress—and I review the chief executive. There is a structure in place all the time.

We are small boards, so the executive directorate meets every week. We now have an integrated management team with the council, and there is beginning to be a coalescence of aims and objectives towards some form of improvement. I am not suggesting that it is perfect or that everyone succeeds to the extent that we might hope, but it is highly structured.

Could you remind me of the other parts of the question?

Ivan McKee: I was interested in how you use that to tackle financial and performance challenges. How do you learn best practice from other boards?

Neil Galbraith: The north of Scotland planning group, which consists of everyone in the north who is now part of the new regional organisation, has existed for the past 15 years, so for a long time we have been collaborating, to a degree, without the formality of the new system.

We are all facing exactly the same financial challenges: we have rising demand and, looking to the future, systems in which we are assuming a 3 per cent pay increase for everyone—and that that money will be included in our budgets so that we can pay for it—and at the same time, every year, we are required to deliver savings of 2 to 3 per cent.

There is a constant focus on bringing about those savings. Some of those savings, having been identified, are not necessarily easy to achieve. As the year progresses, you can begin to see that although the identified savings might have been good suggestions at the time, alternatives are now needed. For example, you will not be too surprised to hear that, since December, we have been working carefully to put a brake on as much as we could because we were in danger of not meeting our statutory obligations. We managed to do so by the end of the financial year, but it was not without some pain and difficulty. There is a constant focus—and I am sure that this is true for every board—on ensuring that we can meet our statutory obligations.

Ivan McKee: It was heartening to see in the Orkney submission that at least one of the charts had upper and lower control limits, so at least someone understands six sigma methodology. That is great to see. Thank you.

The Convener: You have made Ivan McKee's day.

Brian Whittle (South Scotland) (Con): Good morning, panel, and thank you for coming in to give evidence. We are well into the integration of health and social care and care becoming more community focused. It has been interesting to hear in many of your answers how much you talk about community—by necessity because of the areas that you represent. How is integration progressing in your areas? What are the potential challenges for rural communities?

Ian Kinniburgh: I will set the scene before colleagues go into more depth. Integration is something that we in the islands have done intuitively for a good number of years. A lot of joint working took place about 10 years ago. That is when we began the process that has since become enshrined in legislation and the creation of integration joint boards.

Many of the potential gains and the ways that we have collaborated are natural ways of working in the islands. Perhaps it is because we are smaller organisations and we inherently tend to work together. That contributes significantly to what appears to be good performance by the island boards and the island integration authorities against the national outcomes and targets. We started on the journey earlier than some and we have managed to get quite a way along the path.

The legislation and the creation of integration joint boards have possibly had a slightly destabilising effect on the islands, because we suddenly became embroiled in bureaucratic wrangling about who does what and who is accountable for what, whereas previously we just got on with delivering things jointly anyway. However, that has helped us to learn to understand one another better. The health boards and the councils probably have a much better shared understanding of fundamental issues, which is allowing us to unlock some further benefits of integration compared with what we had done previously.

Neil Galbraith: I will echo and add to what Ian Kinniburgh said. In each area, we have one council and one health board, so it has been easier for the boards in the islands to work collaboratively, and there is a long history of that. For example, occupational therapy in the Western Isles has been a combined arrangement for 25 years.

From a Western Isles point of view, the integration joint boards are working well. The first two years were taken up with rather more constitutional questions than was reasonable, and we would have been happier to begin to address some of the problems. However, until we had the boards, bed blocking was regarded as a problem for the health service and not the council, whereas we now recognise that it is a joint problem. Frequently, we end up with bed blocking because of the inability to provide care. The fact that we can move together in an integrated group means that we have been able to reduce a bit what used to be quite a bit of blockage.

Integration has created a bureaucracy that I am not sure was absolutely essential, but at least it has taken us out of the silos that existed before. The health service understands a lot more about how care is provided and what the concerns are on that, just as the council understands that health is much more complex than many people had thought. In the past two and a half years, it has been an entirely positive experience. That does

not mean that we agree all the time, by the way. We are known to disagree, but it is done politically and politely.

Gerry O'Brien: I echo the optimism that my chairman, Ian Kinniburgh, expressed 10 minutes or so ago. Orkney is in a good place in relation to integration. I first joined NHS Orkney as director of finance in, I think, September 2008. We had appointed the first joint director back then, so a lot of the work at an operational level has been going on for many years. I agree with Ian Kinniburgh and Neil Galbraith that integration has not been without bumps in the road, but we are in a good place. The relations between the council and the health board are extremely positive and we will move on well.

I also want to touch on the integration with our Scottish Fire and Rescue Service colleagues and our third sector colleagues, especially with regard to the isles as opposed to Mainland in Orkney. We should take integration to its full extent. It does not need to stop with integration between the council and the health board, and nor should it. We need to consider the economic sustainability of the isles as a group. We have the opportunity to do that not just because of the coterminosity—the single-authority aspect—but because it is the way that we necessarily have to work and it is how the local population views the sustainability of its local communities. The question is how we keep the minister, doctor, nurse, fire station and—I could not leave out my substantive employer—ambulance service going.

Simon Bokor-Ingram: Just about everything that I was going to say has been said but, as an integrated being, I will give a particular view. Shetland had the foresight to get a joint appointment in post well before the IJB came into being. As in Orkney, that was a really good move.

A negative is that integration has brought about some duplication and triplication for a small health and care economy. Personally, I did not foresee the amount of bureaucracy at a certain level that would come from having a third body that needs to report in a number of ways. That has created some work but, at the same time, some of it is highly useful.

A real positive has been the speed of change. It would not be possible for us in Shetland to be where we are without the health and care economies supporting each other with a shared level of understanding, the appearance of a common culture and joint training. The decrease in delayed discharges is probably the biggest headline performance indicator, but there are many other successes behind it.

As Gerry O'Brien said, transformation is not only about the third sector and other statutory bodies. It is very much about the level of leadership, which—as the legislation specifies—needs to be shown more widely, and not just by IJB chief officers. The real positive is that that is happening. It is evident from the conversations that I have with my counterparts in the Western Isles and Orkney that that level of leadership is being shown across the councils, the health boards and the integrated services and other statutory partners who come to the table to discuss this thing called integration. In some ways, it is more of a social movement rather than simply being about service delivery.

Brian Whittle: The previous question was fairly leading, because it was obvious from the earlier answers that collaboration is a necessity in the context of the rurality of your areas. Given that you are further down the track than most on integration, when do you get the opportunity to share that learning with other IJBs?

Simon Bokor-Ingram: There is a national chief officers group, so there is an opportunity there, and the i-hub is supporting the work that is going on. Importantly, a number of other areas of Scotland are doing great work and we are learning from them.

It is a two-way street, and I would not want to suggest that Shetland was further down the road than anywhere else, although we have seen some earlier successes because of our size. Although we have all the diseconomies of scale, there are economies of scale around testing change. I would like more focus and support from the national support agencies in that regard—for example, they could come to test change in the isles as well as on Shetland itself. There is an ideal opportunity to see results emerge relatively quickly, given that one can see the system from end to end. On some days, there are just two steps between me and the very front line, whether that is in health or social care. That can be a really good and powerful model for testing change and to enable us to see the positive and negative effects of what we are doing.

Miles Briggs (Lothian) (Con): Good morning, panel. It is mental health awareness week, as you know, and I want to raise issues around mental health services across the islands. The national standard is for

"90 per cent of patients to commence ... Therapy based treatment within 18 weeks".

The current Scottish average is 76 per cent, and the islands are standing at 63 per cent. In your submissions, you highlight specific workforce challenges in that regard. As health boards, what are you doing to try to provide that service and to bridge what is clearly quite a big gap between the current service and patients' expectations?

Ralph Roberts: I will start, and then Simon Bokor-Ingram will give you some of the detail. That is a very important issue, and I am glad that you have raised it. As a health board, we made a strategic decision a couple of years ago to invest additional resources in mental health however difficult that was in the context of our financial resource. That has been a major focus for us, and we have continued to support the new team as it has come into place. There have been difficulties with recruitment and retention, but as a board we have been clear that we have to focus on mental health.

Simon Bokor-Ingram might want to add something on the psychological therapies target.

Simon Bokor-Ingram: We are not currently meeting the target, which is causing us great concern. Our team is undertaking a development week, in the context of mental health awareness week, on how we are going to meet the target. There are a number of things that we can do, such as providing better signposting to other agencies from which people can receive lower-level interventions quickly. We have a very small service—we have two and a half whole-time equivalent counsellors and one clinical psychologist—and the level of demand has been particularly high over the past year. It does not take a lot to tip us over the edge so that we do not meet the target.

We need to broaden out the skill set to the whole team including community psychiatric nurses and mental health workers. We welcome the extra money that I hope will be coming shortly to fund 800 extra mental health workers for Scotland. At the moment, we are working to identify where the gaps are and estimating what we will need in future to hit a target not just of 90 per cent but of 100 per cent, which is our aspiration.

11:30

Neil Galbraith: In the Western Isles, we have been reviewing the mental health system for the past three years. Two years ago, just before the IJB was brought into being, we widened the whole concept of the review to include the IJB, and we have five working groups that have been working for the past year and a half. We hope to see a report in June and to have a policy statement out and a practice implemented in August of this year. That will be quite a radical shift for the Western Isles. To all intents and purposes, we are still running an old mental health system. This is our chance to get into alignment with the Government's policy on mental health and to do something substantial for the Western Isles.

As you will appreciate, the difficulty is that, by definition, we want to transfer money out of hospitals and into the community. If we could get less pressure on our hospitals while that happens, it would be very helpful. We have those twin pressures on us, but mental health has without a doubt been left rather too long, certainly as far as the Western Isles is concerned. I hope that, because we have had the whole community involved, we will come up with a leading system of mental health provision.

Gerry O'Brien: NHS Orkney is probably a couple of years behind where we would like to be. Ralph Roberts mentioned the investment that NHS Shetland chose to make a couple of years ago, and that is where we would like to be. You will see in our submission that, in our operational plan for this year, we have put mental health at the top of our list.

Our situation is similar to what Ian Kinniburgh described, as we have been dependent on a visiting service for the past 10 years or so, and we have had a variety of locums. The clinical leadership of our service has suffered through that, although that is not to detract from the locums. It is a classic service where our performance up to October 2017 was almost at 80 or 100 per cent, but losing one member of staff—who represented 50 per cent of the service—meant that we suddenly dropped down to 50 or 60 per cent. The challenge for us is to develop the whole system for mental health so that we can remove that person dependency, but that takes us back to specialist skills and availability.

There is definitely commitment from our board. We held a successful event before Christmas that was facilitated by the Orkney Blide Trust, and we have another event scheduled for July, when we will distil recommendations from that report to establish our mental health framework moving forward.

The Convener: I thank the witnesses for a very informative session.

11:33

Meeting suspended.

11:38

On resuming—

Scrutiny of NHS Boards (NHS Ayrshire and Arran)

The Convener: I welcome to the committee Dr Martin Cheyne, chairman; John Burns, chief executive; and Derek Lindsay, director of finance, from NHS Ayrshire and Arran. Agenda item 3 is part of our scrutiny of NHS boards. It follows up on a previous committee appearance by representatives of NHS Ayrshire and Arran, and some correspondence between the committee and the board.

We are keen to hear from you in person in order to understand more fully the position with regard to brokerage and your finances. The upshot of the correspondence between us over the past few months is that the Scottish Government has advised you to return to financial balance and then to consider how to repay the £23 million brokerage that was obtained for the financial year. Although the Scottish Government is entitled to give such advice, it is public money, so we are anxious to know how far your thoughts have gone on the question of how and when you hope to repay the loan.

Dr Martin Cheyne (NHS Ayrshire and Arran): I have not prepared a long opening statement, given the shortage of time this morning. If you are content, convener, we could just go straight into the question-and-answer session.

The Convener: That was my first question. What is your timeframe? When do you expect to begin repaying the loan from the Scottish Government in relation to the financial year just gone?

Dr Cheyne: We have started a process with a number of activities—I will ask the chief executive to go into some detail in a second. Clearly, achieving financial balance within a year will be difficult, and there will be short, medium and long-term plans. We can go into that in some detail to enable the committee to understand what we will achieve. As a board, we have had two very long workshops in recent weeks to discuss the revenue plans for this and future financial years. A great deal of work is being done to try to break down into workstreams what we need to do to get to the point of financial balance. If I may, convener, I will hand over to the chief exec.

John Burns (NHS Ayrshire and Arran): We have had discussions with our colleagues in St Andrew's house; we will introduce a three-year plan to address the challenges that we face, recognising that, although we can continue with short-term initiatives and actions, some of the more transformational changes will take more than one year.

The Convener: I understand that brokerage has not been required by NHS Ayrshire and Arran in the past. Therefore, I am interested in your view as to why brokerage of this scale was required in the year just gone.

John Burns: I will pick up that point. As you say, convener, NHS Ayrshire and Arran has not had brokerage before. We have worked hard to deliver within the resource limits that are provided. However, in 2016-17, we started to see some pressures on our system in relation to increasing demand for unscheduled care and increasing difficulty in recruiting to some key medical posts. Those two elements demonstrated pressure on the system.

We recognised that we needed to work with our health and social care partnerships—we work well together in Ayrshire and Arran—to redesign how we meet the growing need for unscheduled care. Ayrshire has had high levels of use of unscheduled care services, and we recognised that we needed to do further work to redesign the services, in addition to work that had already taken place. For example, we had just opened a new assessment unit.

The second area was medical vacancies. We took the view that we had to bring in locum medical staff to ensure that we maintained safe services for the population, while trying to review how we would recruit to those often hard-to-fill posts and redesign some workforce roles in Ayrshire—for example, doctors in training grades—where we thought that we might not be able to fill all the gaps.

The Convener: You described discussions at St Andrew's house with Scottish Government officials about a three-year financial plan. Is that a plan for achieving financial balance in three years, or for repaying this year's brokerage in three years?

John Burns: The discussions were about delivering a balance in three years and repaying the brokerage beyond that point.

The Convener: Essentially, your expectation is that you will require further brokerage over the two following years.

John Burns: It is regrettable, but we believe that that will be the case.

Brian Whittle: You have outlined plans to close the cancer centre in Ayr and amalgamate it with the one at Crosshouse near Kilmarnock. I have had a lot of mail about that from a patient care perspective, as you might imagine. For example, someone who lives in Ballantrae will have a journey of more than three hours to get their cancer treatment and then a three-hour journey

back. Even if someone drives, you know as well as I do that the parking facilities are inadequate. Was that considered in making the decision? I know that the plan is to have four outlying hubs in the community, but can you deliver those in your current financial situation? The simple question is whether the decision was based on patient care or was basically financial.

11:45

John Burns: The decision has not been taken yet: it is still a proposal. Since we met the committee in December, we have been discussing with our colleagues in the west of Scotland regional cancer network how we will shape the delivery of chemotherapy services in the future. The west of Scotland work, which is progressing, would use the hub model that Brian Whittle described. It is about delivering the right care to patients and recognising the complexity of some of the treatments, but trying to deliver care as locally as possible. We will work with colleagues in the regional cancer network to determine the best way to deliver chemotherapy services in Ayrshire, recognising the points that you have made. However, the drive is absolutely not about efficiency—it is not about saving money. It is about delivering the right care and the best care that we can to patients in Ayrshire.

Brian Whittle: What cognisance is taken of the public transport infrastructure for patients in what is a very wide area? Especially if we take Ayr out of it, the south of Scotland transport infrastructure for getting to Crosshouse is particularly difficult. How are you proposing to deal with that?

John Burns: That will need to be part of the on-going dialogue about any future changes. We will engage appropriately with patients and our communities, and the most appropriate way to do that is to work with the evidence and medical advice about how best to meet the needs of our population in Ayrshire.

If we can deliver the model it might, subject to clinical priorities and pathways, allow us over time to repatriate some chemotherapy to Ayrshire for individuals who currently go to Glasgow. There are wider benefits, but we need to be clear about the benefits in relation to the west of Scotland model and how the service can be properly delivered in Ayrshire, while recognising your points and the transport issues that exist. There is still work to do.

Brian Whittle: How will you consult the general public, and when do you expect to respond to the consultation?

John Burns: I expect us to have a better understanding of the west of Scotland regional cancer chemotherapy model by late June, given the discussions that we have had to date. There is a regional dimension to how we will take that forward, but I want to have clear and proper engagement with patients, staff and our community about why change needs to take place, what the benefits of that change would be and how we can deliver it in a way that tries to address the concerns of our patients, population and staff, where we can.

Brian Whittle: As you are aware, there was a Healthcare Improvement Scotland review into the neonatal unit at Crosshouse hospital. On the back of that, 24 staff were brought into the neonatal unit. If the unit was 24 staff short, which you must have known, that suggests a system under financial pressure. I do not think that you budgeted for the money that is now being spent. What kind of financial pressure are you under? The fact that that patient service was missing from Crosshouse is a financial issue.

John Burns: We invested in nursing staff in 2016-17, including in the maternity unit. We made those decisions in advance of the Healthcare Improvement Scotland review, and they were based on the nursing workforce tools and the reviews that our nurse director had carried out. The board considered that advice and, given the evidence that was presented, we felt that it was right and proper that we invested staff in the maternity unit, which we did.

Brian Whittle: My point is that, if you were 24 staff short in the first instance, there was financial pressure, which is now evidenced by the fact that you are £20 million in the red. We are trying to establish whether, within the financial management of what you are doing just now, you have enough money. Are you getting enough money, and how are you managing to redistribute those finances to get the best possible patient care outcomes?

John Burns: Our focus is on delivering within the funds that we have, and we have clearly not managed that, otherwise we would not have brokerage. There are two immediate threads, the first of which is the short-term immediate changes that we can make in the areas that you would expect us to be looking at around procurement and efficient and effective prescribing. We are also looking at our workforce costs to make sure that we are reducing our reliance on and use of agency and locum spend where we can, to bring those exceptional costs down.

However, we recognise that that is not enough in itself, and that we need to look at how we could change our service model. A number of activities are under way, one of which is in unscheduled care. We are looking at our out-patient services in order to eradicate any waste or unwarranted variation in our processes and to make them as

efficient as they can be. We are also looking at how we utilise our estate.

There are a number of workstreams and threads under way, both with a short-term focus on 2018-19 and with a focus on 2018-19, 2019-20 and 2020-21.

Brian Whittle: Are any other units in Ayrshire and Arran in the same situation as the neonatal unit in Crosshouse was? Do any similar situations need to be addressed?

John Burns: There is nothing on our radar. For the nursing workforce, we have workforce tools—we have just had a review and we are awaiting the findings of that. We have invested in our nursing workforce and we are looking closely at workforce costs. We do not see anything immediate that we have not included in our planning.

Emma Harper: I have a quick supplementary question about cancer pathways and regionalisation. We have the same issues when people go from Stranraer to Edinburgh for their cancer care. I am aware of the regional review and I am interested in whether evidence of any link between travel times and increased mortality is part of the considerations.

I have been asked to look at evidence relating to travel times and mortality. I know that some chemo can be given orally, which makes it easier to give more treatments locally. For some chemo treatments, people have to remain for four hours post-chemo, and sometimes even longer. Some chemo is given via central venous access and some is given through intravenous therapy. There are loads of different ways in which chemo is given, which will be a factor in the decision. However, I am curious about whether an increase in travel time causes an increase in mortality.

John Burns: I do not have the information to answer that question. It is not a matter that I have looked at. We will review all the evidence that comes from the west of Scotland work in considering how we deliver those services, recognising the different ways in which we can now deliver chemotherapy services to the population. However, I do not have any specifics on that question.

Emma Harper: Is there any way of finding out whether travel time impacts on people's ability to recover or whether outcomes are related to travel times?

John Burns: I can ask that question of the team who are looking at the issue, and I am happy to provide information on that to the committee.

Emma Harper: Thank you.

The Convener: You have described a three-year plan, and you said that you expect that brokerage will be required in each of the next two years. What scale of brokerage are you contemplating for those years?

Derek Lindsay (NHS Ayrshire and Arran): The amount of brokerage that will be required will relate to the size of the funding increase that we receive in future years. The Government is planning to publish a medium-term financial plan that will follow on from the UK financial plan, and that is a factor.

At the moment, we have to think about 2018-19. The plan that we submitted in March projected that a potential £20 million would be required for 2018-19. However, that figure will also have to reflect the pay awards. Negotiations on pay are on-going, so we do not yet know what the awards will be or what additional funding we will receive as a result of the consequentials that come to Scotland through Treasury funding for the agenda for change pay awards in England.

There are many contributory factors, but we are in close discussion with the Scottish Government about the different scenarios, and we have said that we expect a lot of those things to be clearer by around the end of May.

The Convener: When you gave evidence in December, you expected a shortfall of £20 million for the current financial year, and that figure subsequently increased by a further £3 million for reasons that you have described. Should we therefore assume that the figure that you have given us today for this year is really only a provisional starting point rather than a final expectation?

Derek Lindsay: It is a provisional figure. Our discussions with the Scottish Government have recognised the variables. Things such as our prescribing costs are also provisional figures that are based on best estimates, but we hope to be able to firm those up in the near future. Pay is our biggest single cost, so we need to be clear about the funding for and the planned expenditure on pay.

Dr Cheyne: It is interesting to note that, in the December board report, we forecasted a £24.2 million deficit. It is a variable figure and a moving feast at all times. The figure has gone from £24.2 million down to £22.9 million. That is not ideal by any means, but it demonstrates the moveability of the numbers.

The Convener: Indeed, but when you gave evidence here in the same month, you predicted a deficit of £20 million rather than £24 million.

John Burns: That is correct, convener. It is a provisional position, and more work is under way in the board. As Derek Lindsay indicated, we have agreed with our colleagues in St Andrew's house

that we will meet them again towards the end of May or at the very beginning of June, when we will set out the next part of the detail of our revenue plan for 2018-19 and the transformational work that we see going into 2019-20 and beyond.

The Convener: My final question is for the chairman. Is it safe to assume that the issue has been discussed in detail at board level? If so, where does the board believe responsibility lies for the shortfall that you have experienced?

Dr Cheyne: Yes, it has been discussed. Most recently, we have had two four-hour board workshops running from about 4 in the afternoon to 8 in the evening, which have gone through the issue in great depth and detail. We have tried to give the chief executive and his corporate management team a degree of support and direction as to what might be acceptable in moving forward with the budget plan, and we will take that to the board meeting in May. At the moment, we are running on last year's revenue rolled forward, because we do not have an agreed budget yet. However, I assure you that board members are fully involved in the discussions in a great deal of detail.

The Convener: That is helpful. You mentioned a board meeting in May and meetings with the Scottish Government towards the end of the month. It would be helpful to the committee if you could let us know the outcome of those meetings with regard to your financial projections.

Brian Whittle: Convener, I should have declared an interest at the start of this evidence session in that a close family member of mine is a healthcare professional in Ayrshire and Arran NHS Board.

The Convener: Thank you for putting that on the record. I thank the witnesses for coming and giving evidence.

We will now move into private session to consider the rest of the agenda.

12:00

Meeting continued in private until 12:21.

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