



OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 17 December 2019

Session 5



The Scottish Parliament
Pàrlamaid na h-Alba

© Parliamentary copyright. Scottish Parliamentary Corporate Body

Information on the Scottish Parliament's copyright policy can be found on the website - www.parliament.scot or by contacting Public Information on 0131 348 5000

Tuesday 17 December 2019

CONTENTS

	Col.
SUBORDINATE LEGISLATION	1
Official Feed and Food Controls (Miscellaneous Amendments) (Scotland) Regulations 2019 (SS1 2019/407)	1
SCRUTINY OF NHS BOARDS (NHS GRAMPIAN)	3

HEALTH AND SPORT COMMITTEE

30th Meeting 2019, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)

*Miles Briggs (Lothian) (Con)

*Alex Cole-Hamilton (Edinburgh Western) (LD)

*David Stewart (Highlands and Islands) (Lab)

David Torrance (Kirkcaldy) (SNP)

*Sandra White (Glasgow Kelvin) (SNP)

*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Rhona Atkinson (NHS Grampian)

Dr Adam Coldwells (NHS Grampian)

Pamela Dudek (Moray Health and Social Care Partnership)

Alan Gray (NHS Grampian)

Sandra Ross (Aberdeen City Health and Social Care Partnership)

Angie Wood (Aberdeenshire Health and Social Care Partnership)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 17 December 2019

[The Convener opened the meeting at 10:00]

Subordinate Legislation

Official Feed and Food Controls (Miscellaneous Amendments) (Scotland) Regulations 2019 (SSI 2019/407)

The Convener (Lewis Macdonald): Good morning and welcome to the Health and Sport Committee's 30th meeting in 2019. We have received apologies from David Torrance MSP. I ask everyone in the room to ensure that mobile phones are off or in silent mode. We will, of course, record and film proceedings, so the proceedings should not be recorded or filmed by anyone else.

The first item on the agenda is consideration of subordinate legislation. The purpose of the Official Feed and Food Controls (Miscellaneous Amendments) (Scotland) Regulations 2019 is to amend existing domestic food and feed law to provide for the execution and enforcement in Scotland of the food and feed elements of the new Official Controls Regulation (EU) 2017/625 and associated tertiary legislation. Do members have any comments on the regulations?

Emma Harper (South Scotland) (SNP): I am interested in whether the statutory instrument is being used to continue to protect our food standards across Scotland and the rest of the United Kingdom. I am specifically interested in the amendment to the Feed (Sampling and Analysis and Specified Undesirable Substances) (Scotland) Regulations 2010. I have concerns about the United States Food and Drug Administration's acceptable level of defects in food that comes from the US. I am curious as to whether the regulations will continue to protect our food standards.

Sandra White (Glasgow Kelvin) (SNP): I understand that the regulations are a continuation of existing law, but I have questions about the public consultation. The information that we have says that five responses were received, but it does not say who was consulted. For clarity, we should know who was consulted and who responded. The businesses that will be affected include slaughterhouses, cutting plants, fish auctions, wholesale fish markets, shellfish operators and those involved in milk and colostrum production. A

huge number of businesses are involved. If possible, I would like to have that information.

I had another issue about the cost to local authorities and others but, having looked at the full papers, I see that it is just over £74 per authority.

I am happy to support the regulations, but I would like clarification about the consultation, if possible.

The Convener: There are a couple of questions for clarification. The essence of the regulations is to bring up to date existing regulations in Scotland, which is required at this stage because the United Kingdom did not leave the European Union at the end of October. The new European regulation comes into force this month, so the update is required in order that we continue to be consistent with European regulation.

On Emma Harper's questions, the regulations do not change the robustness of regulation in this country in relation to any third party, because they maintain the European provisions.

On the points about consultation, separately from deciding on the regulations, we can write to the Scottish Government to ask it to provide us with that information.

Sandra White: I would be happy with that.

The Convener: Subject to those points, do members agree to make no recommendations in relation to the regulations?

Members indicated agreement.

The Convener: As I suggested, we will write to the Scottish Government on the matter of consultation.

Scrutiny of NHS Boards (NHS Grampian)

10:04

The Convener: Under agenda item 2, we will take evidence as part of the committee's on-going scrutiny of national health service boards. We have heard from boards from across Scotland, and today I am delighted to welcome representatives of NHS Grampian and the health and social care partnerships in the Grampian area. I welcome, from NHS Grampian, Rhona Atkinson, who is the vice-chair; Adam Coldwells, who is the deputy chief executive; and Alan Gray, who is the the director of finance. I also welcome Pamela Dudek, who is the chief officer of Moray health and social care partnership; Sandra Ross, who is the chief officer of Aberdeen city health and social care partnership; and Angie Wood, who is the chief officer of Aberdeenshire health and social care partnership. Thank you for the comprehensive information that you have provided in advance.

An on-going issue and concern for NHS Grampian has been balancing the books and ensuring that savings are achieved. Significant progress has been laid out in that regard. What are the greatest challenges for NHS Grampian in achieving future savings?

Alan Gray (NHS Grampian): As we have laid out in our reports, the single biggest challenge is our continued use of a high volume of agency nursing and medical locum staff. We still have a number of shortages in key specialties, and we have a number of challenges in meeting our demand and capacity pressures, particularly in relation to planned care. Those issues remain a challenge. Throughout this year, the use of those two sources of workforce has increased, but we are taking key steps to try to reduce that use and to find a much more sustainable solution in relation to our workforce.

We have a number of things whirring around. We are looking at sourcing, recruitment, retention and the training and development of staff to ensure that we maximise the pipeline of staff who come into the workforce. We have embarked on a long-term strategic partnership with Western Australia to look at how we attract nurses from there. Western Australia has a number of trained nurses whom it is looking to offer opportunities to take up posts in big teaching boards post-graduation. A number have already started to move across to fill key posts in NHS Grampian, which we welcome. We see that as a long-term strategic relationship that will, I hope, allow us to recruit up to about 100 new nurses every year. That will probably double our graduate intake; 100

is roughly the number that we get from the local universities in Aberdeen. We see that as a really positive step forward.

We are looking at all options in relation to medical staffing. The use of medical locums is partly to deal with the backlog relating to our waiting times. The committee will have seen the improvements that we have made in that regard over the past financial year—we are starting to reduce the backlog. As a result, last year, there were 4,000 extra theatre sessions. That staffing is partly to deal with demand capacity and partly to deal with long-term shortages in key areas including mental health, anaesthetics and emergency care.

A number of things will probably help us. Recently, NHS Grampian has been designated as the national centre for extracorporeal membrane oxygenation. That, combined with the major trauma centre, should make our emergency department a much more attractive proposition, which will allow us not only to train the trainees that we have but to bring in professionals from outwith Grampian. We are starting to gain a bit of traction in that regard, in that people are expressing interest in joining our emergency department as a result of those two major services being provided in Grampian, regionally and nationally.

We have taken a number of steps. I could go on for a bit longer, but the workforce cost pressures are probably the single biggest challenge that we face. Most of the other challenges that we face are similar to the cost pressures that most other boards face. For example, the cost of prescribing continues to go up, but we manage that with our resources. We expect to continue to operate within our existing budget and resources. That is our plan, and we hope that that will remain the case.

The Convener: You referred to the major trauma centre, which has been in place for a year and which might have a significant impact on recruitment and retention. Is there evidence that that impact, in terms of keeping people or attracting people to come to the region, is beginning to be felt?

Dr Adam Coldwells (NHS Grampian): At the moment, it is difficult to draw a direct line of sight to that. A very large team is involved in the trauma centre, which spans right across the system, because the centre is partly about people having long-term recovery in the community.

There is a very positive vibe about all this, and we hope to be able to draw a direct line of sight and say that people are definitely staying. It is very positive, particularly for patients and the outcomes for people who suffer major trauma, to have that very holistic pathway of care, from excellent initial

treatment right through to recovery and return to normal living following good rehabilitation. Over a longer period, we will probably be able to see more clearly, as Alan Gray has said, the advantages for staff retention and recruitment.

Sandra White (Glasgow Kelvin) (SNP): Good morning, everyone, and thank you for the update on use of locums, agency nurses and older staff, and on your long-term strategy, including new Australian nurses. I have a couple of questions. Attracting 100 new Australian nurses a year—I think; perhaps you can clarify that—is one of the “various initiatives”. Is that your biggest initiative?

Alan Gray: There are a number of initiatives, of which that is one. We are also considering physician associates, advanced nurse practitioners and a new type of operative to support and increase our capacity in theatres. We are developing a training programme for that which will create 30 new posts every year. We are also creating a new wellbeing post—a post between a registered nurse and a current band 2 worker—to enhance our capacity in wards. We are taking a number of initiatives to develop and broaden our workforce.

We also widening the existing responsibilities of physician associates and advanced nurse practitioners, which have been in the system for quite a while. Those roles will not replace doctors, but will enhance the role of doctors by allowing them to focus on the things for which medics are trained. We are doing a number of things to develop and broaden our workforce, to develop new roles, to clear paths for people to follow, and to create more opportunities for graduates and school leavers to join us. That is our aim.

Sandra White: Do you have a date—not an exact date, but a rough estimate—for when you expect what you are doing to kick in and for the numbers of agency nurses and locums to fall?

Alan Gray: We are already seeing improvement. This year, vacancy numbers have started to decrease. It will probably be two or three years before we see the benefits: some training programmes will take that long to complete, so it will be two or three years before we see operatives filling the new roles. Some benefits, such as from the Australian nurses initiative, we will see in the short term—the nurses are fully qualified and trained and will have quite a rapid transition into our system. It will take two or three years to train physician associates, advanced nurse practitioners, theatre operatives and wellbeing nurses. That is part of a long-term strategy from which we hope to see the benefits over time.

Sandra White: You talked about a long-term strategy and you mentioned older workers, which

is a problem throughout the health service, unfortunately. You are bringing more people in and training them. Is that initiative part of your future workforce planning to address the situation regarding older workers?

Alan Gray: I guess that the age of the workforce is likely to increase. The pension age is now 67, of course, so the age of the workforce is generally going to increase. Part of the solution is to maintain opportunities for staff to work for as long as they can. Can we bring retired staff back in? Quite a lot of staff retire then return as supplementary staff on bank contracts. That offers them some flexibility and allows them to retain and use their professional skills.

The ageing workforce is something that we are all having to use: it is an opportunity as much as a challenge. There is a lot of experience in that workforce, so let us make sure that we create a work environment that has some flexibility and which allows people to work for as long as they wish to work. The current cohort of people who can retire at 60 will start to move away as 67 becomes the norm, so we need to think differently about how we extend opportunities for the workforce over a broader working-age range.

Dr Coldwells: To add to what Alan Gray said, I point out we have a scheme called “My healthy workplace” which tries to support staff to continue to live healthily, to work better, to enjoy their work, to feel healthy in their work, to feel fulfilled and so on.

That involves concentration across the system, in order that we can see how we can support people in work. It is a challenge; some of our jobs are either very physical or require fine motor skills, so we need to support people through the ageing process as well as we can. It is a country-wide challenge.

10:15

Sandra White: I will pick up on that point. It is nice that you are looking at the issue positively, but a lot of people do not want, or are unable to continue, to work until they are 67. Unfortunately, in this day and age, they are being made to work until that age. You talk about initiatives such as staff wellbeing and bringing in new nurses: it appears that you are assuming that the older workforce will work on until they are 67. Do I have the right take on that? You are not assuming that people are not going to return to work because of the heavy workload—for example, nurses having to lift people.

Dr Coldwells: 67 is our national retirement age and the age for the NHS retirement scheme, so we make some assumptions. We are at the tail end of the change between the old and new

schemes, so people in their mid-fifties are probably still on the old one, with a retirement age of 60, but everyone else is on the new 2015 scheme which has a designated retirement age of 67. Therefore, a person who finishes working early will have an actuarial reduction. Again, the trade-off between time and money will be in people's consideration. They will have the right to retire, but retirement will come at a cost in terms of the resource that will be available to them.

Sandra White: I applaud you on the initiative of bringing in Australian nurses and the work on staff wellbeing, but you are basing your workforce planning on the assumption that people will continue to work until they are 67, and that skews the figures a wee bit.

Dr Coldwells: I am sorry. I did not quite understand what you meant when I first responded.

We are looking at the change in the age of retirement and the age at which people stop working in trying to mature our workforce planning. It will vary across the many sorts of roles. It might be interesting to get a perspective from health and social care partnerships on their workforces. For example, the very heavy workload of some care workers is on the spectrum of work. It is early to have a whole model of how people behave in the context of the new retirement age and pension scheme. That understanding is a work in progress, for us.

Pamela Dudek (Moray Health and Social Care Partnership): In the community, there are many and varied roles that can support staff to stay well. We have a fairly healthy older-population profile among staff. My experience of working with communities—I am sure that it is the same for my colleagues—is that lots of staff want to be active. We need to understand the proportion of staff and the level at which they want to be active. Part-time opportunities seem to attract some of our older staff—the idea of having purpose in their day and still being able to contribute seems to be very important to people. We can optimise that by considering the roles in which part-time working is possible.

The other area, which is not employment, but in which we have had a lot of success, is volunteering. At the moment, the volunteering initiative in Moray has a stable volunteer base of about 250 people. In the years for which it has been running, about 550 people have been through the initiative. The oldest volunteer is a 92-year-old who does buddying that deals with loneliness, and the youngest is 17. We are trying to think in much more creative ways and to better understand roles beyond the traditional ones. I could probably talk about that subject for quite some time—it has to be part of the answer.

Sandra White: I am interested in the regional working throughout the north of Scotland that you touched on. I recall that when we took evidence from hospitals including the one in Carlisle, they said that there were difficulties in bringing people in to live in their areas. Do you have a problem getting workers to come to the region?

The Convener: Do you mean regional workers?

Sandra White: Yes.

Dr Coldwells: I will start off, if that is okay. We can then get a perspective from others.

We have a bigger system. It seems to be that the further away from the big cities in the central belt we are, the greater the challenge in recruitment, pretty much across the field of professions. In NHS Grampian, we absolutely see a relationship between recruitment and distance from the city. It is 10 times harder to recruit doctors and social workers in the outer regions of Aberdeenshire than it is to recruit them in the middle of the city. However, the city still faces quite a challenge, when compared with Edinburgh or Glasgow. We have observed a definite micro relationship and a more macro relationship across the country.

Rhona Atkinson (NHS Grampian): The chief executives across the north of Scotland have strong conversations going on at the moment, because we recognise that there is a supply issue in a great many of the skills that we are looking for. There is also what we are trying to do through the trauma centre. People will stay if the jobs are made more interesting. There is a logic to that.

There are also strong conversations going on about having to make cross-boundary working work. That is good for patients, families and people who live in the area, and the attraction rate goes up with it. It is very early days, but there is certainly support across all the boards that are involved in those conversations.

David Stewart (Highlands and Islands) (Lab): I want to raise a specific point that I have raised several times in the committee. I have a genuine concern about United Kingdom Treasury rules on pensions. The issue has been raised by the British Medical Association and is in *The BMJ* almost weekly. You will know that the Department of Health and Social Care in England looked at it, and a plaster was put on. I have raised the matter with the Cabinet Secretary for Health and Sport, and some work has been done on it. It particularly affects doctors, although any member of staff, particularly staff who are on a final salary scheme, could be affected.

What has been the effect of the rules on NHS Grampian in respect of retention? A key issue is full-time working. My experience is that the

problems start to hit home with post-55 consultants. Is that your experience in NHS Grampian?

Dr Coldwells: I will start, and Alan Gray will follow.

The anecdote is absolutely staggering. I am of a similar age. I grew up with lots of those folks and have known and worked with them for 25 years. It is a common conversation when we meet—just yesterday, a general practitioner talked about it, so it is not just about hospital-based doctors. The situation is very challenging. Because GPs are self-employed, the GP regulation is even stricter than the bit of sticking plaster that we recently put on in Scotland.

Alan Gray has been working on the issue, so he might have more evidence-based stuff. It really is a live issue that is largely about people being unable to predict what will happen, which is really putting them off.

I will go back to primary care and general practice, which are two years in arrears because of how they do their accounting. The issue has caught out many GPs—I do not know a better description than that. There is a real risk, so anything that we can do to prevent all the worry that we have heard about in *The BMJ*, for example, would be extremely valuable.

David Stewart: The difficulty is that the issue has crept up on staff. Initially, the lifetime allowance was at quite a high level. In fairness—I am always fair—successive Governments have looked at that as being a great boost to the Treasury. The last time I looked, the lifetime allowance was £1.03 million. That sounds a lot, but a consultant who is on a final salary scheme can easily pick that up by their mid-50s. My concern for management is that it can say that it knows how many medical students will graduate in year 1 and that, in 40 years, they will be full-time equivalent, but they will not be, because by the time they are in their 50s, if they have a decent financial adviser, they will say that they would be mad to work full time because they will take a huge tax hit. That seems to me to be a perverse consequence. I understand why the Treasury is doing it, but what is the point of doing that with one hand while the other is trying to invest in the NHS? That makes no sense at all.

Alan Gray: I will make a couple of points in response to that. Consultants will be hit much earlier than their mid-50s. It will affect those who are now in their early 30s, who will hit their lifetime allowance in their late 40s.

We do not know what decisions consultants will make, but the issue is certainly having an effect on their decisions about when they will retire and leave the service. Some are planning now when

they are likely to leave the service, let alone when they are likely to retire.

Consultants are still picking up waiting list initiatives. They are doing their 10 core programmed activities, but a lot of them are dropping additional sessions beyond their core 10 PA contract. That is where we are seeing the most immediate effect. We are losing capacity, because they do not consider the work to be worth their while. They are already taking a heavy tax hit and there is a premium on their annual allowances, so there is no incentive to take on additional sessions, which are essential in provision of patient care.

Clearly, planning for doctors and medics could change radically. The issue has, as David Stewart suggests, come out of the blue: we have not planned for it and we have been hit in a way that we had not expected. I think that it will have a detrimental effect on doctors in the short to medium term. Doctors have options—they have alternative ways to use their skills and they have other career options.

That was a great question. We must keep an eye on the issue, so I welcome the committee's interest in the matter and thank members for that.

Rhona Atkinson: In Grampian, our pensions manager has done a great deal of work in explaining what the implications are for consultants and nurses who are approaching their lifetime allowance and what mitigations can be put in place. They are not given guidance, but the pensions manager makes them better prepared, including by getting them to speak to financial advisers. There can be a knee-jerk reaction to a situation that looks negative, so they walk away, but our approach allows them to find space to work through and plan the best route for them. That has given us a bit of leeway, too.

Miles Briggs (Lothian) (Con): Good morning. First, I will ask a few questions about financial management. In Parliament, members across the political spectrum often mention that NHS Grampian has been underfunded for more than 20 years. What is your view on the NHS Scotland resource allocation committee funding formula over that period? Does the formula disadvantage NHS Grampian?

Alan Gray: I have been working very closely with the Scottish Government since I was appointed eight years ago to address the funding gap in NHS Grampian. I am pleased to say that, over that time, we have made good progress towards alignment with the NRAC target allocation, which we are now within 0.8 per cent of. I recognise that, historically, the board has been challenged. Throughout the period, we balanced the financial position—that is, we

operated within the allocated resources. I am very pleased that we are now much closer to the target allocation.

NHS Grampian faces a residual challenge—probably one other board in Scotland faces the same challenge—to do with its population. Its population share is about 11 per cent, but our allocation based on the NRAC funding formula is 9.9 per cent. We have a 1.1 per cent funding differential, when most boards are largely funded in line with their population level share. That 1.1 per cent translates to a large sum when some £9 billion of resources is allocated every year.

The one thing that remains a challenge for us is that our per capita funding is less than the funding that most other boards get. However, I am pleased that the commitment was given to get us to the NRAC target allocation. That has been great—it has allowed us to invest significantly in services, and we have seen the benefit of that.

I am pleased with where we have got to on the issue. I would welcome an open mind being kept in relation to the fact that our per capita funding is a bit more challenging than that of most of the large teaching hospital boards in Scotland. We are working on that, and we have good strong links with the Scottish Government's health directorate. It understands the challenge and it is keen to look at the issue with us to determine whether the health needs of Grampian are much less than the needs of the rest of Scotland.

Miles Briggs: I want to look at cancer performance. Stats that have been published today by ISD Scotland outline slight improvement across Scotland in the 62-day treatment standard for cancer. That is not the case in Grampian, where there has been a decline from 86.8 per cent to 79.7 per cent in June. What is the reason for that?

Alan Gray: The main reason is that we are dealing with a backlog of patients. We are breaching the target for patients who have been waiting longest. A slight performance dip is to be expected as we eat into and reduce the backlog.

We still face challenges with two types of cancer treatment—neurological and colorectal. We are putting additional capacity into all stages in the pathway, from diagnostics through to treatment, over the next three months in order to try to eat further into the backlog.

I accept that performance is not what we would like it to be. In addition to addressing the backlog, we are also seeing more patients now. I hope that in a year we will be able to say that we have made significant progress towards achieving the 62-day and 31-day waiting targets. It is a priority for the board—we are focused on it and know that we need to do better.

We have in place plans to address the capacity gaps, most of which are short-term solutions. To go back to the earlier question, we have a plan to try to increase our capacity across the major areas in the one-stop diagnostic facility in order to get people in and diagnosed without the need for multiple visits, so that we can get them on a treatment path for radiotherapy, chemotherapy, surgery or whatever is required.

10:30

Miles Briggs: Is that a workforce challenge or an equipment issue? What is the rationale?

Alan Gray: It is partly about diagnostic equipment. We have brought in additional MRI capacity on a temporary basis to address that issue. Most of the challenge relates to staffing: we have many vulnerabilities across pathways where the service or part of the pathway depends on a single practitioner. We are trying to address that and to build in resilience. However, it takes time to recruit, train and embed practitioners in the pathway.

Emma Harper: I am interested in information on waiting times. Our briefing tells us that NHS Grampian received additional funding from the Scottish Government through the waiting times improvement plan, which is intended to support health boards to improve waiting times across a range of services, including cancer and diagnostics, on which we have just touched.

In its mid-year briefing, NHS Grampian notes that the number of treatment time guarantee patients waiting over 78 weeks was on an increasing trajectory from early 2018, and that it peaked in April 2019 at about 450 people. It now seems to be decreasing, which is good news. How is the additional funding being used to tackle waiting times?

Alan Gray: I am happy to answer that question as well, given that it is covered by my remit. We were allocated £12.8 million as part of our waiting times improvement plan. We have invested about £5 million of that in recurring capacity—that relates to the question that Miles Briggs asked about building capacity—across several specialties, which builds resilience into the system. We are using the remaining money to bring in additional capacity through a range of private sector contracts. Those contracts are providing capacity at Dr Gray's hospital and Stracathro hospital—where we are looking to maximise availability of the theatres in the area—as well as additional capacity on the Aberdeen royal infirmary site. About £7 million is spent in the independent sector.

I will share some numbers on performance—although I hope that that information is in the

briefing. In January, we had 16,000 patients who were waiting on an out-patient waiting list beyond their treatment time guarantee. That is now down to 8,500 as of the most recent reports from last week. We had 5,200 patients waiting more than 26 weeks on out-patient lists at the start of the calendar year and that figure is now down to 2,500, which is almost a 50 per cent reduction. There is almost a 50 per cent reduction overall on out-patient waiting lists. That shows the progress that we have made.

At the beginning of the year we had just under 6,000 patients waiting for in-patient care, and the most recent figures show that there are 4,000 patients in that position. We still have a large number of patients waiting for care, but it is a significant improvement on the beginning of the year. The trajectory shows a steady decrease in numbers, month on month. We are hoping to continue to make progress on that through the next stage of the waiting time programme—we submitted a copy of that programme to the committee.

We welcome the money. I can guarantee that every penny of it is going into additional capacity. That has been really helping us to improve our performance. As I said earlier, we have had 4,000 more people in our theatres this year than we had last year. That is great because it means that 4,000 more people have been treated, as well as that more people are being treated on time. I hope that the committee will agree that the money has been well used and invested, and I hope that we will continue on that trajectory.

Emma Harper: I know that there are challenges in relation to people on waiting lists, given that we have an increasingly elderly population, which means that more people will need hip replacements, knee replacements and so on. To prepare patients for surgery we have to make sure that their clotting time, coagulation and warfarin levels are all within limits that will mean that they have safe surgery and optimal recovery. As a nurse, I understand how we prepare patients for surgery. If people who are on a waiting list for total hip or knee replacement or having their gallbladder removed or whatever are not meeting the parameters for safe surgery, they remain on the list. Can that sometimes skew the numbers and make it appear that patients are waiting longer, when in fact it is because they are not necessarily fit for their surgery yet?

The Convener: In other words, do the numbers that we have here reflect the exclusion of people who are not fit for surgery, for example?

Dr Coldwells: We follow the rules that are set out by the Government on people's clocks starting and stopping because of availability to be treated. People coming to pre-surgery and needing to lose

weight so that they are fit for anaesthetic is one of the most common issues, and their clock stops while they are addressing that. They then come back and their clock starts again, which is in line with the rules that are set out for everyone who is resident in Scotland.

Emma Harper: I know that we are getting better at screening patients for bowel, breast and cervical cancers, so if we are screening more people, that means challenges for the process of supporting people for chemo, surgery or radiotherapy.

Alan Gray: Screening is fundamentally a good thing to do. There are screening promotions in which people are encouraged to go along to their doctors or use the bowel screening kit. They create a bit of need for capacity in the system, but that is for us to manage.

The screening programmes are a good thing. Early diagnosis means that patients end up with much better outcomes and better longer-term health. The programmes are good but we have to find a way of managing the fluxes in capacity that they generate. Encouraging people to be screened and get check ups as appropriate is definitely the right thing to do because we identify things much earlier, and if we can intervene earlier, the outcomes are so much better.

I just want to reassure you. Every single one of the patients who are waiting on an in-patient waiting list has been risk assessed. NHS Grampian has a system whereby we risk assess every single patient and put them into one of three categories. Patients who have to be seen within a one-month to eight-week window require urgent access to in-patient care and they are properly prioritised within the system. Patients who are on the list are evaluated and they continue to be evaluated. If their conditions change, they are asked to be referred back to the consultant or go back to their GP. We do not wait. We actively monitor people on the waiting list to ensure that we are doing what we can and that, if things change, we are able to respond to that as required.

Emma Harper: I assume that you continually assess for the downward trajectory of waiting times to make sure that Government support is being achieved.

Alan Gray: Absolutely. We want fewer people to have long waits. It is not good for anyone to have a long wait. The quicker the access that we can provide, the better.

The current position is that we are down to about 100 people who have been waiting for 78 weeks in a couple of specialties. We are also providing additional capacity in Dr Gray's and Stracathro hospitals to deal with those long waits

over the next six months. That number is coming down. It is still higher than we would like but there has been a significant improvement on where we were at the beginning of the year.

Emma Harper: So instead of 450 people waiting for longer than 78 weeks, there are now 150.

Alan Gray: I have the exact numbers. The number I had this morning was just over 100. It is significantly better on all fronts. Thank you for the question.

Sandra White: Delayed discharge is a huge issue for all health boards. I will combine my two questions. In October this year, 3,470 beds were occupied under delayed discharge. In September this year, the performance report to the board noted:

“Health and Social Care Partnerships are introducing additional efforts to reduce patients being delayed in hospital”.

What are the main drivers of delayed discharge? What steps are being taken by the integration joint boards to reduce delayed discharge?

Sandra Ross (Aberdeen City Health and Social Care Partnership): A lot of the key drivers for people staying in hospital are about placement in the community: care at home or another suitable destination such as care homes or other areas where they are supported to go home.

We have looked at delayed discharge across the whole system to see what we can do to help people to get home. We have looked at a number of areas, such as the discharge-to-assess approach, which helps people to get out of hospital a lot sooner, especially if they already have a care package in place. We have worked with housing colleagues, across the partnerships, to see whether we can utilise sheltered and very sheltered accommodation to provide supported hospital-discharges beds. We are working with acute services to make better use of occupational therapy and care management, through in-reach work.

Pamela Dudek: It is important to highlight that our overall performance in Grampian tends to be better than the Scottish average. However, we still have a number of people who are delayed and we are looking to minimise the number. It is a complex system. There is a lot of focus on the matter, pretty much on a daily basis, because the whole system contributes to how good, bad or indifferent that number is.

The availability of care is a big issue for all of us, and it relates to the social care and home care workforce, which is a challenge right across the system. That is a hot topic for us at the moment.

However, it would be remiss of me not to acknowledge that there is an issue to do with how we have historically worked with people who are in hospital and their families, compared with how we need to work, to ensure that everyone understands the importance of getting a person through the hospital system and home, so that they maintain their independence.

That is an on-going conversation. Committee members spend time in their communities, so you will all have come across people who have a strong belief that hospital is the best place for someone. That is not the message that we are trying to put out. We are still working on our relationships, to ensure that people understand what all that means for individuals and families.

Across the patch, the three chief officers work closely with the chief officer of the acute sector. We meet every week, and delayed discharge is probably one of the main topics. We talk about where we are, what else we can do and how we can get people together to come up with new ideas. That is positive. At times, that work has a huge impact; at other times, things stabilise and there is a bit of a challenge for us. There are multiple efforts around the issue.

In Moray, we have a number of housing initiatives, such as extra-care housing, which is provided through our partnership with Hanover (Scotland) Housing Association. Our use of care homes is pretty static; there is no rise in requirement for care homes, because we seem to have the right environment to enable people to remain independent and stay in their homes.

However, we continue to face challenges to do with workforce in home care. That can be the rate-limiting factor.

The Convener: For clarity, did you say that Grampian's performance on delayed discharge is better than the Scottish average? Is that true for all three IJBs?

Pamela Dudek: Yes.

Angie Wood (Aberdeenshire Health and Social Care Partnership): In Aberdeenshire, we often speak about delayed discharge, as do my colleagues in Aberdeen city and Moray. At the IJB, we have been supported to try to understand the people behind the numbers. Increasingly, we see that hospital is not the right place to make decisions about a person's future provision, given the trauma of being in an acute centre, so we are working closely across the three partnerships and the acute sector to see how we can get people home to make those decisions.

In Aberdeenshire, there is always a bit of an issue to do with distance and getting people in touch with their local teams. We work closely with

the acute sector to ensure that there is care management and allied health professions input, so that assessment can start while a person is in that sector, with a view to getting them support at home, even if it will not be on an on-going basis, so that they do not have to make those decisions while they are in the acute environment.

Sandra Ross: It would be remiss of me not to say that, although delayed discharge is a large focus for us, across the whole system we are particularly focused on preventing admissions. We understand that if we are to prevent delayed discharge, people need to be supported at home for longer. Each IJB has a variation on hospital at home. We work with our primary care colleagues as well as with secondary care and the whole system to consider how we can prevent people from coming into hospital. As part of planning for this winter, we have a large marketing campaign called “Know who to turn to”, which is about redirecting and using all the resources that we have from the Scottish Government and locally to divert people away from hospital and support them in that way.

10:45

Sandra White: I am glad that you mentioned that last point, because I find that, more than anything else, there is a lack of joined-up working—not just in your area but in other areas. You mentioned delayed discharge and care packages, but sometimes the package is not there. In that situation, are people referred back from the doctor or occupational therapist? Can you track patients? If a patient supposedly has a care package in place and is then discharged and the care package is not there, do you know about that? Some of my constituents are discharged but are then back in again fairly quickly because no package is in place. How joined up is the approach? I know that you have a huge area compared with my area, which is Glasgow Kelvin, so how does that work for you?

Dr Coldwells: I will make a contextual remark before I ask Angie Wood or another colleague to come in.

One thing that we are really proud of is how well we have grasped integration. We have strong relationships between NHS Grampian and the three council areas of city, shire and Moray. We have spent five years developing what we believe is a fantastic integration model for the north-east of Scotland. We believe that we have developed that with a real sense of localism. There are differences between Moray, city and shire, but they are appropriate differences for the populations, which are quite different.

In our submission pack, you will have seen a response on integration to the ministerial strategic group for health and community care. We felt that we provided a mature and realistic self-assessment, with things that we need to do together to make the approach really good, as well as stuff that we absolutely think that we do well. Part of that has been at the board—in October this year, the board considered a report on all our reflections. That is a cohesive improvement plan for each part individually and for the institutions that then work in partnership together. We hope that, after today, we leave you with the message that we think that we have kind of got the hang of this integration thing.

If it is okay, I will ask one of my colleagues to respond to the question about tracking patients in integrated teams.

Pamela Dudek: I am happy to answer that. The answer is yes, we can track patients. For example, when I get a query, which happens almost daily, my team is immediately able to come back and say that they know the person and the issue is in hand, which is reassuring. Sometimes, the story that comes in is not completely in line with what we find when the information comes back. Moray is not big, so it is not difficult to join up the teams, and they have a history of working in an integrated way. With Dr Gray's, our unscheduled care in Moray is pretty much contained, and the teams meet regularly—there are daily huddles. We absolutely can track patients and pick up issues.

Sandra Ross: I echo Pam Dudek's point. In Aberdeen city, we have care managers in social work areas, and their discharge co-ordinators are based in acute services. There is daily consideration of who is going where. If somebody goes home and that is not at the right time or the time that they would look for, and perhaps the full package is not available, they remain on a list. We constantly monitor that list.

Angie Wood: To build on what my colleagues said, I give assurance on the way that the partnerships work with the acute sector. There is a daily huddle. When a patient goes into the acute sector, we are much better at not feeling that they are no longer the community team's responsibility; they absolutely are our responsibility. We share information and think about what the patient needs not just today but in three, four or five days, so that we can start to get ahead and plan much better. The beauty of the integrated services is that, if a care package is not delivered, that still sits at my door—and at all our doors—so it is in all our interests to make sure that that happens well.

Sandra White: I read the notes. I want to put that on the record, because not everyone reads the notes.—[Laughter.]

Alex Cole-Hamilton (Edinburgh Western)

(LD): I, too, would like to talk about waiting times, particularly for child and adolescent mental health services. As of the quarter ending June 2019, nearly half of all patients were seen beyond the 18-weeks treatment time guarantee.

I will come back to that in detail in a minute. First, for the benefit of the committee, I would like to understand the landscape for child and adolescent mental health in Grampian, particularly around tier 4. At the start of this parliamentary session, there were no tier 4 beds north of Dundee. What do you do when children need in-patient psychiatric care?

Alan Gray: We seldom admit children to a residential or patient care facility. We have the facility in Dundee. I do not have the exact numbers, but the admission numbers are very low. Our model is about supporting patients to stay in Grampian with the appropriate professionals around them. Our aim is not to admit. Because of the distance, admission takes people away from their families, which is not a good outcome. Short-term admissions might be appropriate. Based on current activity, we do not see the need to develop something in Grampian.

The meeting paper references the fact that, in June, we did a major redesign of our CAMHS system. We now have a service that covers all children from 0 to 18. There are no transitions within that service. We have co-located all our Aberdeenshire and Aberdeen city services in one purpose-built centre in the city of Aberdeen, which is going down well—it opened in July. Because people do not have to travel, that has allowed us to create 24 per cent additional capacity; it has allowed us to put all the professionals into one area. Feedback from carers and patients is that having the services in one place makes them more accessible and the centre does not feel like a big hospital—it feels like a place that has in mind the person who is coming for care and support. When the patient is there for their assessment, they can be seen by multiple professionals on that day, because they are all in one place. We do not have to refer them to multiple professionals to get an assessment. They can get an assessment in one day and quickly be put on a treatment package.

Alex Cole-Hamilton: That sounds gratifying. It is clearly a rationalisation and it makes a lot of sense. Are you seeing an empirical change in the waiting times?

Alan Gray: Yes. The management information from the end of October is that 71 per cent of patients are seen within the treatment time guarantee. We aim to get to the 90 per cent target by the end of the next calendar year. We are confident that we can do that.

In Grampian, we have the choice and partnership approach—CAPA—model, which involves a two-stage assessment. Patients are given a comprehensive assessment by a multidisciplinary team. However, that does not count in relation to the waiting time, which is counted only when the patient has started the next stage—that is, the treatment stage. We have been working with the guidelines to look at how we get recognition for that first assessment, which starts treatment, because it signposts people to immediate opportunities for support and help. All our patients are seen within six to eight weeks; that first assessment happens within six to eight weeks. People do not wait for a long time to be seen, but waiting times are measured in a way that presents a picture of people waiting a long time to be seen by professionals. They do not.

We are trying to address that gap between assessment and treatment, which is now six to eight weeks—it is longer in the Moray area, where there are one or two challenges around capacity, which we are addressing. In this calendar year, I hope that you will see a significant improvement in our performance. More children are being seen, assessed and given the first stage of treatment within that time period. We are in a much better place than we were in 12 months ago.

Pamela Dudek: In Moray, there is work to be done and that is progressing. There is a confidence around the improvements. They are getting to the right place. I always say that CAMHS is an end point. When it comes to resilience, early intervention and prevention, we need to focus on the outcomes for our children. In Moray, we have had a journey around children's services, from a poor inspection to making good progress at the beginning of last year and being in a good place, where we were described as knowing ourselves and knowing what else we needed to do.

The big focus now is on our new integrated children's services plan, which is due for publication across all three areas on 1 April. The priority in Moray is mental health and wellbeing, on which we have been doing a lot of work. We are involved in the realigning children's services improvement programme, which is a national collaborative. We are in the process of completing our strategic needs assessment, which has given us a clear indication of what we need to do, and we have looked outwards at areas that are doing well in that arena, which, unsurprisingly, seem to follow a pattern of having integrated teams around school catchment areas that take the stress and distress out of schools, thereby supporting the wellbeing of children and families. It has been a real eye-opener for us to be able to embrace the concept of listening to the voices of children and their families through that programme and to

understand what it is that we are trying to respond to. Many families would benefit from such early intervention and would probably never need to go near CAMHS.

Alex Cole-Hamilton: That is good to hear. It is great that you are seeking to take the stress and distress out of schools, and we know that access to a talking therapist as soon as young people start to feel unwell is the best way of preventing them from needing to enter CAMHS in the first place. Would you say that children in schools in the area have universal access to such provision, or is access patchy?

Pamela Dudek: I would say that access to such provision is still variable, certainly in my patch. Through the new plan, the ambition is to address that with our multiple resources through joint commissioning. Again, integration is at the heart of the process, including with the third sector and our local resources and people—

Alex Cole-Hamilton: It is your aim for everybody to have early access to a talking therapist.

Pamela Dudek: Yes.

The Convener: Another issue that was raised when we consulted the public on the provision of services by NHS Grampian was the provision of psychological therapy services in primary care, specifically in Moray. The provision of such services is being enabled across the country by Scottish Government funding, but there appears to be a particular issue in Moray. Could you help us to get a better understanding of that, please?

Pamela Dudek: I do not know that I clearly understand the background to the queries that have been raised, but I can talk about the general mental health approach in Moray. We are in year 4 of our strategy—

The Convener: For clarification, my question was about the provision of psychological therapy in primary care.

Pamela Dudek: Through our primary care improvement plans, we have the action 15 money, which we have joined up with the funding that we have for the broader interventions. A number of initiatives, including some that are commissioned and some that operate within surgeries, are under way. They include the provision of link workers and the distress brief intervention. With Penumbra, we are part of the national improvement programme. With the Scottish Association for Mental Health locally, we have a wellbeing centre that provides a number of interventions that are linked to primary care. We are talking about a pathway of care. It is not the case that everything sits within the GP surgery, but there is a link with the GP surgery to provide a response to people

who are suffering from stress and distress in adulthood.

We also have a particular focus on young males, because of the prevalence of young men taking their own lives. That initiative extends right across Moray. We have quite a number of interventions at that stage that are not GP led but are led by the wider system, and which take an integrated approach.

In addition, there is a social movement known as the wellbeing hub, whereby a number of people with lived experience who are champions across Moray are involved in the delivery of cognitive behavioural therapy based approaches in local community centres.

It would probably be useful to find out some of the specifics of the issue that you raise outwith this arena to determine whether we can respond positively. We are taking a number of actions in that area.

The Convener: The suggestion was that the unit for the provision of psychological therapy in primary care in Moray is being closed down while such provision is being expanded elsewhere in the country.

Pamela Dudek: No, that is not the case.

The Convener: We have heard a bit about access to therapy in schools and other points about young people's ability to access mental health and wellbeing services in Moray. Are there comparable services in Aberdeen and Aberdeenshire?

11:00

Angie Wood: One of the major benefits of integration relates to not just health and social care, but our ability to integrate more widely across other NHS and, indeed, council systems. In Aberdeenshire, although the IJB does not have responsibility, or delegated responsibility, for children's services, we have strong and developing relationships with our colleagues in education and children's services. We are hoping to take forward a number of pieces of work to join up services so that schools, and the young people who are at those schools, feel more supported. For ourselves, as a rural area, it is possibly more important that people feel integrated and can identify those forms of support in their own communities.

The increase in resources and the CAMHS changes have absolutely been of benefit across Aberdeenshire. It is about working at that very local level to make young people and their families feel supported in their own communities, and working differently with education so that we can think about what different could look like.

Sandra Ross: I echo the feedback from Pam Dudek and Angie Wood. We are working strongly with education to make sure that we have good support, the ambition being that we have equity of service across the city. Psychology is available in primary care, and we have moved forward with our link workers, which helps with tiers 1 and 2. We have link workers in every one of our GP practices, which allows for early intervention and positive signposting and helps people to move forward.

David Stewart: I want to talk about services in Moray, in particular at Dr Gray's hospital. I refer the panel to the feedback from NHS Grampian's public consultation. I will quote four separate consultees, who each said something interesting about services.

The first said:

"The current situation of staff shortages and the abysmal state of Maternity Services smacks of utter contempt of Moray patients by NHS Management based in Aberdeen."

The second asked whether Moray and Dr Gray's get "a particularly bad deal?" The third said:

"Dr Gray's is very much treated as the poor relative by Aberdeen Management. The disregard for Moray patients is patently obvious to anyone living in Moray"

and the fourth said:

"While acknowledging and thankful for the caring staff at Dr Gray's surely it is time to address the fact that we do not have a hospital capable of serving the needs of the residents. Surely this is clear to everyone when anyone from a baby to an elderly person is forced to travel to Aberdeen to access clinics, treatments, operations, procedures etc etc ... Politicians must admit that Moray is not served well and deserves better."

Those four individuals are quite critical of the situation. I would like the panel's views on service provision, particularly at Dr Gray's in Moray.

Dr Coldwells: I will start by setting out the context of how we work and how we include Moray, and Pam Dudek—who leads there—will follow.

For those who are not familiar with the set-up, Elgin is about 70 miles north of Aberdeen and sits in the Moray area. As Pam Dudek described, Moray has a well-contained DGH that has tremendous relationships with primary and community care. For lots of people, it is a really holistic system that manages their condition or illness locally, which is absolutely as we would want it to be.

We have a joined-up system leadership team, of which Pam Dudek is a member. She has recently taken on a leadership role for all of Moray, including Dr Gray's hospital. However, lots of the acute elements of waiting times are still supported from Aberdeen, so that the system is part of a holistic pathway of care for people who are on a

waiting list. We have a really clear view that Moray is absolutely part of our system. We support it with really joined-up and very senior leadership through Pam Dudek, in order to make that work across primary and acute services. I am sure that she will add to that.

The Convener: Before Pamela Dudek comes in, I want to clarify whether you are describing a situation in which much of the responsibility for the leadership of the district general hospital now lies with the IJB—not directly with NHS Grampian—because it has been integrated with other services in the Moray area.

Dr Coldwells: I will be really pedantic, if you do not mind.

The Convener: Not at all.

Dr Coldwells: The responsibility does not lie with the integration joint board, because the IJB is the board, but with the health and social care partnership through Pam Dudek's relationship with our chief executive, Professor Amanda Croft—who is really sorry that she could not be here today—with support across the Moray system. It is quite a difficult relationship to describe because theatres and so on are not delegated to the IJB. It is about working productively in order to have senior leadership locally. As I said, Pam Dudek is part of our system leadership team, and I hope that she feels very supported from Aberdeen.

Pamela Dudek: To clarify, my operational responsibilities have been signed off by the IJB. Although it has not been delegated, the IJB agreed the executive leadership role that I was asked to take at the end of last year. That decision was made because it made sense for things to be local and because many of the activities that were being looked at already related to the wider local system.

I recognise all the comments that Mr Stewart quoted; I have heard them being made many times by many people. In Moray, there is a perception and a belief that that is the situation. However, there are alternative views, so we have to step back a bit to try to work out where the truth of the matter lies.

As I have said, from my experience in Dr Gray's hospital, we hold our own on scheduled care. All such care takes place locally; a person would go to Aberdeen only if they had a severe issue that could not be dealt with in Moray. A small number of frail and elderly people have found themselves in Aberdeen, but they have gone there in very specific circumstances. We contain and deal with our people locally, which is a huge part of our business.

There have been very challenging experiences across the hospital in relation to aspects of

women's and children's services. I see it as my daily job to look across at things as they are, what they have been and what we need for the future. The way in which services have operated, with the luxury of the staffing and other provision that we had historically, is very different from where we are now. We have talked about pensions and our ageing workforce, and we have looked at what has worked well. There have been changes from what we could configure and deliver in the past. People find it hard to get their head around that and to see why changes need to be made, because they have had a good service from Dr Gray's, which has a dedicated and passionate staff. We see that from the fact that most people who work in Moray live in Moray, so there is another level of commitment in that regard.

The women's and children's services aspect has been extremely tricky and complex. The public's perspective is that there is a move to try to remove Dr Gray's from the system and that there is no investment and support for the hospital. I have spoken to many people who have that view, and I have been able to give a number of examples of investment. There has been no cap on overspends, and there have been quite significant overspends in trying to deliver a good service. Of course, the workforce challenge is probably the most prevalent one.

In the past year, we have received significant funding and additional leadership to support me in trying to address the situation at Dr Gray's and in being clear about how we can run things in the future for the good of the local population and as part of the network.

We have worked through the paediatric challenge. We have worked with the community through a planning process, and we are now moving into an implementation phase. That work has gone very well.

NHS Grampian has approved extra funds for four additional paediatricians in the system. We are confident, because our offer is attractive and sits in the context of an on-call rota across the Grampian system, that we will have recruited individuals to those posts by February. We have an alternative model that has been consulted on and is now going ahead. Things have moved on well on the paediatric side.

However, maternity provision continues to be a huge challenge for us. We are not working in a static landscape: the regulations change, and staff availability varies as people move on. Over the past year, the resources that we thought we had could change within a week. We are currently trying to resolve challenges around the anaesthetics service, which is the backbone of a small acute care hospital. Without the right capacity in place, we would be unable to perform

certain tasks in obstetrics, including consultant-led obstetrics. We are working actively on that as we speak. In addition, there is a question around the number of obstetricians that will be required, depending on the nature of services and the requirements for optimisation.

We have set up a board to oversee the transformation of services, which I chair along with Paul Bachoo, who is the medical director for acute services. We have met twice so far and have looked at all the data and the strategic needs assessment for adults, and we are working through how we can prioritise those vulnerable areas.

I have had significant investment from NHS Grampian to assist me in that work, and we have some really positive stories to tell. Last week, we recruited people to a number of posts in orthopaedics that we had previously struggled to fill. In addition, over the past six months, we have had significant external interest in other posts in the hospital and in the partnership, and we are now recruiting. However, I understand that actions speak louder than words and that, until people feel confident in the position of maternity services, we will continue to be challenged on whether we are committed to that area.

David Stewart: It is certainly good to hear a number of positives in your comments. I stress that the consultation responses that I quoted praised front-line staff as well, and I can echo that praise from my own experience.

I took two things from the chief medical officer's advisory group report, "Maternity and Paediatric Services at Dr Gray's Hospital, Elgin", which came out last month. First, there is a need to improve communication with expectant mothers and front-line staff. Secondly, it is necessary to improve morale and empower staff. The report, which is effectively a Scottish Government report, is another piece of evidence. What work has been done to cover those two areas? I appreciate that the report came out only last month, but has any initial work been done to address those concerns?

Pamela Dudek: We have already been trying to work closely with staff across the hospital on morale. A lot of the statements on morale will stem from people thinking about whether we are going to have a hospital in the future and whether they feel confident about that. We have tried to communicate clearly the commitment in that regard; our thoughts have been presented at board level, in public session, to demonstrate the commitment of the board and the leadership team. We have said that we expect that we will, going forward, have a district general hospital in Elgin, but that we face challenges in respect of the shape of the provision and how services are delivered.

The local team has been tasked with having regular meetings with staff. We are addressing capacity issues by expanding the management team so that leadership and management have the time and space to support staff in the correct way. A number of activities are taking place. The visibility of the leadership team is important, and we are carrying out surveys—for example, we are looking at our iMatter staff survey results to understand where we need to target resources and how we take provision forward. That work is continuing.

I have forgotten the second part of your question.

David Stewart: The two parts were on communication with expectant mothers and front-line staff, and the issue of raising morale and empowering staff.

Pamela Dudek: We have spent a considerable amount of time with our community midwives, who will be the main point of contact for any expectant mum. We are trying to ensure that they feel confident in their role and are equipped to be able to work effectively with expectant mums. Contact with the obstetrician is another touch point, but the community midwife is the main contact.

We also got one of our team-leader community midwives to make a short film that talks through and tries to address all the concerns that we are aware of. That goes out on social media frequently and is on our Facebook page for mums to look at if they have any concerns.

11:15

Rhona Atkinson: As a board member for the past five years, I can fully understand where the comments that David Stewart quoted came from. The whole Dr Gray's scenario has been a significant learning exercise for the board and the clinicians on how we build that hospital to have a future in the area and how we complement the cross-boundary services that come into Grampian from Highland.

One of the main issues has been communication. It relates to all aspects of the health board's communications about how support for Dr Gray's would continue. There was never any intention to do anything other than make it a hospital for the future. However, until just recently, we have not taken a step back to see what the future holds; we have just been fixing the immediate problems. The report that David Stewart referred to and the other reviews that are on-going have allowed us to create that space and to say, "We know what is not right, but fixing that is not necessarily the way forward." The way forward is for us to think about what the future must look

like for those people. We need to take people with us in moving through to that new position.

That work is now starting, and we have already had some early successes. However, it will take quite some time to persuade the people of Moray that they will have a hospital that is of use to them and that it will be there for some time to come. As a board member, I am now more assured that we are set on a path that will get us to that place, rather than simply having knee-jerk reactions to individual situations.

David Stewart: I am sure that the public in Moray will be gratified to hear your comments. What I was picking up was uncertainty about the future of the hospital as a whole and certain aspects of the care that is currently delivered. That is certainly an anxiety.

Rhona Atkinson: Absolutely.

David Stewart: Getting the message out to the public that it is "safe in our hands"—to use a quote from another context—is very important.

Emma Harper: I have a couple of questions about pain and chronic pain management. Chronic pain management is a specialty that has been identified as a priority by the Scottish access collaborative, which was created in October 2017 to sustainably improve waiting times for non-emergency procedures.

I am interested in issues around chronic pain management. We have had a few submissions that specifically focused on access to pain management, access to consultants, issues around tramadol, gabapentin and fentanyl prescribing, as well as the value of face-to-face clinic visits versus telephone conversations. There seems to be a perception that telephone conversations are not necessarily the best way to support someone with chronic pain. There are also views around whether people are seeing the right person, whether that is a doctor, a nurse who might be a pain specialist or an allied health professional.

What action is the board taking to ensure that waiting times for chronic pain clinics are reduced? What are you doing to support chronic pain services provision?

Dr Coldwells: First, I absolutely acknowledge that support for patients with chronic pain is not at the point that we want it to be at. We have been working with a group for several years to try to improve our provision.

Some of our approach relates to our earlier workforce discussion, particularly in relation to the chronic pain service that is delivered through anaesthetics—pain specialists and anaesthetists. The volume issue could never be solved just by

having more anaesthetists doing the work—that is not the solution.

We have tried to think about a much bigger framework that would allow chronic pain to be better managed and supported, rather than just treating everything—as members will know, that is not a solution for a significant number of people who suffer from chronic pain. We have put one of our psychologists in charge of that work.

In that wider framework, we are now thinking about how we support people with chronic pain, as well as those who respond well to treatment. That is allowing us to have a different approach that is joined up across both primary and secondary care, with that specialist bit drawing on the anaesthetics specialists and pain relief devices, where appropriate, alongside work to support people with psychological interventions to learn to manage pain much better. A chronic pain condition is an awful thing for people to have to face, but we need to manage pain when it cannot be treated. We are trying to see how we can get a holistic view of chronic pain in that population.

As well as taking those steps, we have appointed more staff, including some physiotherapists, in order to build a multidisciplinary team. The work is starting to gather momentum. As Alan Gray described, we are on a positive trajectory to improve chronic pain waiting times. That is one of the indices, but I hope that we are getting into the guts of the problem to support people to live with a chronic pain condition.

Emma Harper: One of the consultation responses was from a person who had waited 10 months to see a physiotherapist. Her acute pain could have been better treated with an early intervention instead of having that 10-month wait, which will have resulted in a more chronic need. That is a challenge to ensure that we have faster access.

Dr Coldwells: Absolutely, and I apologise to that person. That might have been part of the transition between what we were able to deliver in Moray and what we deliver as a Grampian system. I will give the context and explain that. There has, over time, been a transition from the small workforce that Pam Dudek described. Someone who had an interest in chronic pain left, which created a gap, and we could never recruit a person to mimic someone who had developed a small special interest as part of a wider portfolio. That created a gap in our ability to deal with people in the Moray area, but there is now a better joined-up system. We are absolutely on to what Emma Harper described—rapid access to support the acute part while we get people on to pathways to support them with their chronic pain.

Emma Harper: It is interesting that there is a lot of crossover between mental health issues, pain management and primary care support so that people do not get to an acute phase. What work is being done to support people while they are waiting to see a pain management specialist?

Dr Coldwells: There are a number of things. Sandra Ross might want to comment.

Sandra Ross: As part of our primary care improvement plan, we are looking to have first-contact practitioners in each of our GP practices so that GPs can refer or signpost people to start wellbeing activity or other early intervention work while they are waiting.

As Adam Coldwells said, there are a number of projects. We are linking with public health to give that more holistic view about managing people's chronic pain, as well as the treatment and interventions. A range of things are already taking place.

Pamela Dudek: GPs will tell you that the majority of chronic pain is handled in primary care, and their plea for support is important. I will meet the Moray pain group in January, and it will be interesting to follow the matter up with the group.

Within the primary care improvement arena and our health and wellbeing arena, we need to think differently about the workforce that is available to us and the wider workforce that can contribute. We will be looking to take forward a conversation on that very thing with our GP advisory group and others. Given that we do not have enough physios to cover every post that we are creating, is there a different way to consider our leisure estate, where there are physios and personal trainers who can do early intervention and prevention around musculoskeletal conditions?

We are keen to pursue that conversation because, more and more, we have to think beyond the traditional workforce. Who else can be in the team that supports the population locally, not to keep people away from specialists but to ensure that specialists see only the complex cases that require their intervention?

Emma Harper: You talked about GPs being the people who look after most patients up front, in primary care. One of the other consultation responses was from somebody who could not get a GP appointment for four weeks. Do GP appointment models fit what people need? People have various shift patterns and working times. Some people might not be able to get to a GP appointment until 5, 6 or 7 o'clock in the evening. I know that different models are being tried in other parts of Scotland. For instance, some GPs have early appointments, before 7 o'clock in the morning. Is work being done on how the IJB or the

health board can support GPs to take a different approach to appointment access?

Pamela Dudek: That is all part of the work that we are involved in on in-hours and out-of-hours services. Our out-of-hours general medical service has real challenges, which are workforce based. We are considering the opportunities that technology provides. Every GP surgery in Grampian now has the Attend Anywhere e-consult capability. However, it would be remiss of us to put that in without any business change or consideration of who uses it and how. Work is being done with certain surgeries that are learning about where that approach has best value. That offers flexibility that might make a difference to how we operate our opening times.

We do not have solutions to all those issues yet, but we are trying to work through them. We are considering when people need to see a GP, when we can use our wider workforce and when we can use technology. Through all that work, we hope to see a different level of responsiveness over time. For some people, there is no requirement for an immediate response, and different practices have different ways in which to manage that.

Sandra Ross: To build on what Pam Dudek said about the four-week waiting time, I note that it is also about the triage model. Earlier, I spoke about our “Know who to turn to” campaign, which is about using the whole system, from pharmacy through to other practitioners and other areas, and really focusing on prevention and self-management. Measures such as bringing in the Attend Anywhere technology, looking at positive triage models and using our wider team will certainly help to improve the situation. However, to go back to Emma Harper’s point about looking at flexible working across seven days and early working, there are other solutions that will help to take that forward.

Pamela Dudek: NHS 24 has tried a really good model at Riverside medical practice in Musselburgh. We are looking to learn from that and to see how we can build on that experience.

Dr Coldwells: I make a slightly wider point about the GP challenge that Emma Harper described and which is reflected in the appointments issue. A key part of our clinical strategy is to think about unscheduled care, planned care, self-management and prevention. The thrust of the clinical strategy is about how we move stuff from unscheduled to planned care, and from planned to self-managed care, and how we prevent primary, secondary or tertiary disease or whatever in everything that we do. Self-management is absolutely key to changing the relationship between patients and statutory provision of service, whether by GPs, nurses or anyone in a primary or secondary care team, and,

indeed, in a social care team. You will have seen in our submission pack that we are pushing the “Scotland’s house of care” model. Again, that is about trying to change the paradigm of consulting so that the patient has a much higher level of responsibility and ability to interact with the healthcare team and can then manage their condition differently and much better.

The number of people in our population with chronic disease who access primary care is absolutely enormous. I cannot remember the exact number, but a really big proportion of the total is driven by chronic disease. We hope that by supporting people to self-manage we will shift that paradigm, and that the demand for appointments day after day, with the doctor in particular, will change over time. We are trying to create descriptions of how people access primary care, because the current situation is not okay, and we need to do something until we have that new system working. However, our bigger model and the picture that we are trying to paint are about the shift of activity down that continuum, and self-management is a key to success in the future.

Emma Harper: Rural GPs in my South Scotland region have criticised the new GP contract, which was negotiated by the BMA and the Scottish Government. Obviously, Grampian is a rural region. How is the GP contract working there?

Angie Wood: I have been involved a lot in the introduction of the new GP contract. We have had real success in our collaboration and discussions with local GP sub-committees, and through engagement with the practices. You are absolutely right: the same concerns were raised and continue to be raised across some of our practices. We have looked at the memorandum of understanding and thought about how we develop services within our area. Across all the partnerships, we are lucky to have strong clinical leadership from the GPs and practices and in our management teams, to take that process forward.

11:30

Our relationship with the Grampian GP sub-committee, which is the BMA representative in the area, has allowed us to explore our options. It is about on-going engagement and testing change—because sometimes we just got on with things. I hope that we will learn from that. Again, because of the way that the three partnerships work together, we can test approaches in one area and then see what the learning might be for others. It is about constantly checking in. We are working closely together.

We have also been up front about the impact on the whole system. We could go out and advertise a whole heap of jobs in one area, but what would

that do to the whole system, and what would it mean for the patients who are receiving services? I would not say that the situation has been without challenge, because it has not, but we have seen some good successes. As Pamela Dudek described, we could say that the model is built around physios and therefore that is the only function that we will develop, but actually we are quick to suggest that we might have other resources, which we could use in different ways.

Pamela Dudek: To give some assurance, Angie Wood and I both sit on the national rural group and have been involved in all its conversations, so we are well tapped into that.

About three months ago, we had our visit from the Government team, which included all the clinical leads, all the leads for primary care in the three partnerships, primary care contracts—which I host on behalf of NHS Grampian and the three partnerships—and our local medical committee and GP sub-committee reps, and we were complimented on the way that we work together. Our LMC and GP sub reps were complimentary—unprompted—about their relationship with us and where we had got to, which was an endorsement for us as a management team. It was reassuring to hear that our relationship is in the right place and that we are having the right conversations, although we have many challenges.

Emma Harper: The GP contract is about a multidisciplinary team approach in primary care. In evidence to the committee, witnesses have said that we need a national engagement plan to teach folk about who they need to see—that could be a physio, a dietician or a different member of the team. Is the health board taking forward work in which the GP contract includes a multidisciplinary team? How would you support that engagement process in primary care? Have you done any work to educate the public about changes that are happening in healthcare?

Pamela Dudek: We find it difficult to think about matters in isolation, because the whole integration agenda is a mirror of what we need to do with the primary care contract.

There is a lot of debate about having some national messages, and perhaps there is no harm in having those, but my experience of working with localities is that the best way to get people functioning well within their area is by working with the population to understand what is available in a locality and how they can start to navigate it. The resources are different in different localities, so we sometimes configure on the basis of what we have.

The public have some great ideas. For example, in Forres, we decommissioned the community hospital, with the community. That was quite a

difficult thing to do, but we continue to work with that community on our evolving model. The community council works with the community on the messaging about that model, and we are looking at working up a community asset transfer, taking into account what that might mean for health and wellbeing. Working with the community is perhaps much more powerful and meaningful than a national campaign, although I am not saying that a campaign would not add weight.

Sandra Ross: Just to add to the point about the whole area of working within our community, we are firmly based within our local outcomes improvement plans, working with our community planning partners, who have a significant role to play in primary care, as well. Some of the messaging that Pam Dudek described gets taken across from our work with those partners, as well.

Brian Whittle (South Scotland) (Con): My interest lies very much in the prevention agenda, which has been mentioned several times today, and specifically in what has been described as the obesity epidemic and the impact that obesity has on so many other conditions, such as type 2 diabetes, chronic obstructive pulmonary disease, heart disease, MSK disorders and mental health.

We should look at the people who look after us. There is a lot of evidence that front-line staff are less healthy than the people whom they are trying to treat. We were talking earlier about the retirement age and the impact that ill-health can have on retirement and absenteeism; how are you tackling that? How will you create an environment in which your healthcare professionals have the opportunity to have a healthy, active lifestyle?

Dr Coldwells: I shall start, but I think that everyone will have something to say about that. The director of public health's annual report this year was on obesity and activity. It was presented to Rhona Atkinson's board this month and sets the context for Grampian. Two out of three of our adult population are overweight or obese and there is a challenge in helping people to understand their weight and healthy weight. It is a community-wide challenge and the report talks about how we start to tackle the stigma and all the challenges around people having a healthy weight.

Brian Whittle referred to the staff, which is a key issue that we identified in our clinical strategy. We published our clinical strategy a couple of years ago, which has the four blocks that I described—unscheduled care, planned care, self-management and prevention—and a number of cross-cutting themes. One of the cross-cutting themes—the things that enable us to deliver the strategy—is about our staff and their wellbeing, and it includes their having healthy weight, not smoking, drinking sensibly and exercising.

As part of supporting our staff to have those good aspects of a healthy life, there is all the stuff that you would expect around the healthy working lives programme. NHS Grampian registers healthy working lives, and each partnership pursues healthy working lives with all their staff—there is quite a breadth, because obviously all sorts of council staff are involved, as well. We have approached the issue through that system. Some organisations have gold awards and some have bronze and are building up to gold. We have a system-wide approach towards a healthy workforce.

We are doing quite a lot, in different management teams, around wellbeing, including mental wellbeing. I think that we have moved on from describing people as being resilient to asking how people thrive in a challenging environment. There is a sense that delivering health or social care will probably never be easy, and we are trying to move from that idea of resilience, as I said, to one of thriving in challenging situations. All that comes together as a package.

We are clear that we have not fixed this or got the ultimate solution, but the issue is high on the system leadership team agenda. We are wrapping wellbeing into the culture and supporting people to have a really positive workplace, which is largely about how we all behave in an environment. We have a systematic approach to a programme of rolling out a really positive culture. As I said, we do not think that we have fixed everything, but we are conscious that we have a number of building blocks that will help our staff.

Talking to someone about their obesity is a very challenging conversation for a health professional who is trying to build trust in a consulting relationship—it is one of the most commonly reported challenges. We have programmes of work to support people to have those challenging conversations. Catherine Calderwood has published reports on realistic medicine, part of which is about the consulting method, which will help people to have more productive conversations about people's weight.

I apologise. That was a long answer.

Rhona Atkinson: Some of the things that I am going to say might seem small but their impact is significant.

In Grampian, we do a lot about quality improvement. Recently, I was in Elgin to see the most recent cohort to complete the course on quality improvement. A successful project that appealed to everybody was one in which nurses in a ward took the initiative to persuade all the caring and kind families who brought chocolates in to say thank you, to change their gifts to fruit. If there are

chocolates there, people will eat them. That is a given.

Brian Whittle: Absolutely.—[*Laughter.*]

Rhona Atkinson: People changed from giving chocolates to giving fruit, and the patients also started to eat more fruit. There were other signs of that being beneficial.

There has also been a great spread of values-based reflective practice. That does not directly take us to obesity, which was the focus of Brian Whittle's question, but it is about teams getting together at the end of a particularly hard shift and finding a way for people to talk through what has happened and care for one another, so that when they go home they do not take that burden with them and do something unhealthy. When people leave, they are in a better state of mind.

As a whole, the organisation is going for Magnet accreditation—that is largely through the nursing workforce, but it applies to everybody. Magnet is about teams taking responsibility for themselves. In Grampian, we are clear that if we are going to get culture change we cannot do it to people; people have to come with us and make changes themselves. Magnet is helping staff to do that. Nursing teams are gaining power to control their own environment—how they raise money, how they spend it and how they help one another to be better teams.

These are small things and there is no great corporate drive for it all to happen, but the more you give people the power to help themselves, the more they do that.

Brian Whittle: I am glad that you talked about culture change. As a society, that is what we need. I am interested in how we lead that, from a healthcare professional's perspective. You talked about how difficult it is for a healthcare professional to start the conversation with somebody in a surgery. How do you start that conversation with a healthcare professional? More important, how do we stop people being obese in the first instance? How are you measuring the impact of the change?

Sandra Ross: I can give a small example of that. We recently undertook a survey in which we looked at our strategic plan for the care of older people. As a large part of that, we focused on people who are of working age and who are coming up to being older. We found that, for a large percentage of people who responded, the messages are getting across. People know what a healthy diet is and how much exercise they should be taking. The problem is that it is not easy enough.

We have started conversations with our joint staff forum to ask how, as employers, the NHS,

IJBs and partnerships can make it easier for our staff to make healthier choices. There are simple things, such as the fruit initiative that Rhona Atkinson described. How do we build in exercise? How do we get breaks? How do we make it easier for people to have an active lifestyle? On Turas, there is now information about helping people to have those early conversations and helping us to have those conversations with staff.

Brian Whittle: I will move on slightly. Alan Gray mentioned the rise in the cost to the health board of prescriptions. If we do not change the trajectory and strategy on health and we do not make the cultural shift that we were talking about, the burden and strain on the health service will become intolerable. Alan Gray gave the specific example of the rising cost of prescriptions. We have heard a lot of compelling evidence on the importance of social prescribing, instead of prescribing medication.

Where are you with regard to the third sector organisations that we have talked about and utilising social prescribing as opposed to medicalising problems?

11:45

Sandra Ross: The use of social prescribing represents a really big shift. People in the partnership and in our wider system have been down to England, where a lot of progress has been made on social prescribing, to look at what is happening there. We are also considering how we can start to look at social prescribing in our primary care improvement plan.

The social prescribing component is quite significant, and we are working on it with our third sector partners. I am sorry—the other point that I wanted to make has totally gone out of my head.

The Convener: It has been a long session; we are nearly done.

Angie Wood: This is on a slightly different topic, but I have certainly noticed that the discussions that take place in the community planning partnerships have changed. Recently, the director of public health came to speak to the CPP board. There has definitely been a shift in view, whereby we are no longer talking about things that need to be treated but about things that can be prevented. The prevention agenda sits not just in the health service or the health and social care partnership but in wider society. An interesting example is the leisure industry; it attracts a lot of people in the north-east, but some parts of it are perhaps not the most healthy. As well as looking at our role, we need to address the challenge of asking our partners about that wider society role. We are seeing an interesting change in that regard.

The Convener: The committee has recommended that IJBs should work towards spending 5 per cent of their budgets on social prescribing. Do you have a sense of where you stand in that regard and of how achievable that target might be?

Sandra Ross: What I was going to say in response to a previous question has come back to me—it links in with the question that you have just asked.

I do not have a percentage to give you, but we are looking to make our commissioning approach far more user-led, so that it is about the people who use the service. Traditionally, people who have received day care have come along to receive it during the day and have gone home at night, but we are now much more involved in partnership working with our third sector and our sport and leisure providers. Through self-directed support, we are giving people independence so that, instead of being prescribed activities, they can choose which services to access, which helps with the early intervention and prevention agenda.

Pamela Dudek: We recently revisited what the percentage of spending on social prescribing was in our IJB on the basis of a report that was done by our director of public health about three or four years ago, and found that it was about 4 per cent. We are looking to build on that.

There is not always a direct correlation between what happens in a GP practice and the social prescribing that is done under a different banner across our communities. Like others, we have done a huge number of activities, including holding vintage tea parties, “boogie in the bar” events and ball groups, which are all underpinned by health promotion support and conversations about being active and making good life choices. A huge number of activities that go on across our communities every week fall into that category. I think that our leisure people will hold us to account as much as the third sector will. That is the beauty of community planning and IJBs, which involve a wider partnership: people will say, “That’s not good enough—we could contribute more if you work with us.”

Brian Whittle: Rhona Atkinson made the point that there is no single magic bullet and that lots of little things will contribute to the achievement of the shift that we want to see. It strikes me that the real preventative work is done at the very start of life. One thing that can prevent children from becoming obese or developing obesity in later life is being breast fed when they are younger. How are you doing on promoting that? Are you pushing that? Where are you in that respect?

The Convener: Does Adam Coldwells want to take that?

Dr Coldwells: I am happy to do that. I might confuse Aberdeenshire with Grampian at times, so I ask you to forgive me for that.

We have received an award from UNICEF—I cannot quite remember what it is called, but it relates to our support for new mums to maximise their ability to breastfeed. That is one of the key elements of our approach.

We are moving to a new midwifery model under “The Best Start: A Five Year Forward Plan for Maternity and Neonatal Care in Scotland”. The other day, we had a fantastic presentation from a midwife who is now working across the system. That approach provides a sense of continuity for a mother in the community, during labour and afterwards. Continuity of care makes a difference and leads to a big increase across a number of very positive measures. That includes the likelihood of people being successful at breastfeeding, as they have confidence in the contact that they have with professionals and develop a relationship in which they get support from someone whom they come to know.

The new model is now being rolled out—it has already been implemented in a couple of patches in the city and somewhere up in Moray. Aberdeenshire is on the list of boards that will soon start to implement the plan for their midwives. We believe that the new midwifery model will make a difference in various aspects around birth and the continuing relationship with mothers, which will provide for a very good early start to life. In addition, there are a lot of other programmes in place; Angie Wood referred to working differently with schools and in other areas, which builds up support through children’s early lives.

David Stewart: I will move on. Can the panel members provide examples of best practice in the field of technology and digital in their health board area?

Dr Coldwells: Sandra Ross is our tech thrasher, so she might want to start.

Sandra Ross: It is difficult to give examples of best practice in technology—it depends on whether we are talking about progress on technology-enabled care such as devices, or on the whole digital agenda to enable us to work as part of a joined-up collaborative system. If we are to work in that way, there is work to do not only in NHS Grampian but at a national level to support that agenda. We are keen to support progress in that regard.

At local level, we are working closely with technology. Recently, we moved our health visitors forward in using Cambric Systems Ltd’s Morse app, which five other health boards already have in place. It helps us to get our records

digitised, so within five years all the children in the city—Aberdeenshire and Moray will probably follow on—will have digital records. We are part of an early-adopter programme for tech systems that help us to record information on people who have suffered abuse. We have also had some experience with the ARMD—age-related macular degeneration—programme, which has recently been tested in some areas and has led to a reduction in falls to zero. We are testing that approach just now. The digitisation of patient records is the big area of technology that we are developing.

Dr Coldwells: I will give some context on the slightly wider picture; perhaps I should have done that earlier.

Almost everything that makes a difference will rest on a single digital record—that is the fundamental building block, and we are moving closer and closer to digital records being an absolute reality for people. A lot of work has been happening in all sorts of areas. We are trialling the digitisation of health and social care records across the whole health and social care team so that people can see appropriate—I hate using that word—data from every professional who is involved in the care and support of an individual. That is the fundamental building block.

Sandra Ross has given a couple of good examples from primary care. In secondary care, we are working with asynchronous consulting for out-patients. That basically means that, in a consulting relationship, I establish with you which data are needed; your role is to tell me what is needed. I am then able to explore the options with you—although not in real time. That works very well for lots of chronic conditions. It seeks to produce between a 30 and 50 per cent efficiency in the consulting role of the doctor. With regard to the huge out-patient challenge, on which Alan Gray described great progress, we believe that technology will enable us to make a real difference in how we can better support the volume of people in the system.

The other really exciting thing—which goes slightly wider than digital technology—is that we have a small team of people who lead on innovation. The sense of that is about how we change our paradigm in innovation, and us asking the innovators to fix a long-standing problem, which is a different approach from just having innovators telling us what we might do. We are gathering some real momentum with that. They are the guys who brought forward an app to support people in consulting on dermatology—it does not really matter that it works through an app. We are really excited about reporting on that and sharing it across the country. Although it is still

at a very early stage, it looks extraordinarily promising—it is real, if you see what I mean.

David Stewart: I think that that is realistic.

I know that time is tight, convener. However, I want to talk—finally—about technology in relation to fighting the tyranny of distance. You have more than 3,000 square miles in your board's area—it is huge. I also want to tie in the issue of regionalisation and how you collaborate with other boards.

Let me give you an example. I have a local campaign in my area of Highland to have a PET scanner—for those who were off school that day, I clarify that PET stands for positron emission tomography. Obviously, if that campaign were successful, a scanner in Inverness would—as we talked about earlier—provide scanning for the bulk of Moray. Instead of just having one board on its own say, “This is a good idea for our 400 patients who need to travel to Aberdeen, Dundee, Edinburgh and Glasgow”, you could benefit from a collaboration. From a quick look at the geography, I imagine that the bulk of people in Moray would be better going to Inverness than to Aberdeen. Is that the sort of conversation that you have had with neighbouring boards?

Alan Gray: Yes. We have just published our regional asset management plan—we have an asset management plan for the whole region. On what David Stewart said, there is a combination of asset management plans across Highland, Orkney, the Western Isles, Tayside and Grampian NHS boards. We now have a combined plan and we are working to see where there are opportunities to work together on some of the investments around diagnostics, the use of hospitals and the whole digital strategy.

I hope that the committee will see that evolve over time, as we now have that combined plan. The plan was published by the Grampian board in December and it has been approved by the chief executive, so there is an absolute commitment to work together to maximise the use of resources and investments, and infrastructure and assets, across the north of Scotland. David Stewart is absolutely right, and we will aim to do that, and to build on it, in the coming years.

Brian Whittle: There is not a technology problem in healthcare. Having worked in healthcare tech, I know that there is so much really good technology out there that is not currently being utilised. The problem is the adoption of technology—there are so many great pilots gathering dust on shelves. The question is how we take that technology and give front-line staff the time to adopt it and to personally develop, so that we can cascade it into the front line.

Dr Coldwells: I agree with that—and that should not be exclusive to technology; it should include all sorts of best practice. Although we have not yet resolved it, we have been giving a bit of thought to the issue of the gap between a good proof of concept and things working in pilots, and rolling them out at scale.

For me, the best metaphor comes from “Dragons’ Den” and the development of curry sauce. Developing curry sauce in your kitchen is one thing. However, to make it commercially, you do not just get bigger saucepans and bigger burners; rather, you have to completely reconstruct the ingredients, because doing something at scale is fundamentally different to doing it as a small test or pilot. The reason why healthcare struggles to do stuff at scale is because it thinks that you just do it with bigger saucepans, when, fundamentally, that is not the case. I made reference to the innovation team. Interestingly, one of the things that we have tasked it with is thinking about the transformation model that we need when we have a fantastic example of something that works in one specialty, practice or team.

When we develop stuff, we put in a tonne of resource, and there is a lot of interest when people are developing the wheel, which is the exciting bit. However, when people are told, “This wheel is a really great thing to do”, they do not have the same investment and personal buy-in. We need to reconstruct how we make things happen at scale. I would be delighted to share that with the committee when we have fixed that with the innovation team, because it is a common theme in lots of the problems that we observe and get really frustrated by.

12:00

The Convener: That is the cue for me to say that I am sure that we will come back to you for further information, as required, once we have had a discussion about the evidence that we have taken today.

It has been striking to hear how much the health board and the three health and social care partnerships are approaching matters in a shared way. Very briefly, would it be fair to say that that level of integration and that joined-up approach is supported by the health board and by the three local authorities in your area?

Rhona Atkinson: I will answer very briefly. In covering for the chair at the moment, I attend the NHS chairs meetings once a month, where integration is a regular topic. From hearing what they say about their scenarios in comparison with what we are experiencing in Grampian, it seems that we have quite unique integration across all

the partners. We are not the only place where that is happening—there are some other places. However, given what I am picking up from other areas, I think that in Grampian it is much better established and it is starting to move forward—instead of us just talking about how it should be.

The Convener: I thank witnesses for a very full evidence session.

12:01

Meeting continued in private until 12:21.

This is the final edition of the *Official Report* of this meeting. It is part of the Scottish Parliament *Official Report* archive and has been sent for legal deposit.

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

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000

Textphone: 0800 092 7100

Email: sp.info@parliament.scot



The Scottish Parliament
Pàrlamaid na h-Alba