OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 5 December 2017

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 5 December 2017

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HEALTH AND SPORT COMMITTEE
29th Meeting 2017, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Ash Denham (Edinburgh Eastern) (SNP)

COMMITTEE MEMBERS

*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Jenny Gilruth (Mid Fife and Glenrothes) (SNP)
*Emma Harper (South Scotland) (SNP)
*Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor Sir Harry Burns
John Burns (NHS Ayrshire and Arran)
Dr Martin Cheyne (NHS Ayrshire and Arran)
Tim Eltringham (South Ayrshire Health and Social Care Partnership)
Derek Lindsay (NHS Ayrshire and Arran)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 5 December 2017

[The Convener opened the meeting at 10:01]

European Union Reporter

The Convener (Neil Findlay): Good morning and welcome to the 29th meeting of the Health and Sport Committee in 2017. I ask everyone in the room to ensure that their mobile phones are switched to silent. You can use them for social media, but please do not take photographs or record proceedings.

Agenda item 1 is the selection of a new European Union reporter to work alongside Brian Whittle, who is another EU reporter on the committee. I invite any comments from members.

Alex Cole-Hamilton (Edinburgh Western) (LD): I move that Brian Whittle be an EU reporter.

The Convener: He is already an EU reporter.

Alex Cole-Hamilton: Sorry. I move that Emma Harper become an EU reporter. My apologies, convener.

The Convener: Thank you. If there are no other comments, it is agreed that Emma Harper will be the new committee EU reporter. Congratulations, Emma. Thank you very much.

Scrutiny of NHS Boards (NHS Ayrshire and Arran)

10:02

The Convener: Item 2 is scrutiny of NHS boards, for which we have guests from Ayrshire and Arran this morning. I welcome to the committee John Burns, chief executive, NHS Ayrshire and Arran; Dr Martin Cheyne, chairman, NHS Ayrshire and Arran; Derek Lindsay, director of finance, NHS Ayrshire and Arran; and Tim Eltringham, director, South Ayrshire health and social care partnership. I invite one or all of you to make an opening statement.

Dr Martin Cheyne (NHS Ayrshire and Arran): Thank you, convener—you have done the introductions for me. We have submitted a briefing paper to you, which I hope has been helpful for members.

NHS Ayrshire and Arran, like many health systems, faces many challenges as the needs of our population change, and it is essential that we continue to adapt and innovate to meet those challenges.

As a board we realise that we have a duty to use the resources that are available to us to support prevention and to deliver care and treatment to our population. In doing so we recognise that we wish to do this in a way that reflects the ambition of the triple aim of best value, better health and better care.

Our teams working across health and social care are committed to delivering the best services possible to our population, and we have a strong approach to continuous improvement.

As chairman of the board, I can assure you that we scrutinise the performance of our services through our governance arrangements, and we have set out the way we do that in the briefing paper. At the recent annual review, the Cabinet Secretary for Health and Sport asked the non-executive directors whether they felt that they received the information that they needed, as well as any additional information that they sought in order to fulfil their scrutiny and assurance role. In response, the non-executive directors were clear that they felt well supported and that they would ask for and receive additional information if required. I think that that reflects what John Burns and I have tried to do in developing an open culture in NHS Ayrshire and Arran, which values all staff and the important contribution that they make.

The Convener: Thank you. I ask Ivan McKee to begin.

Ivan McKee (Glasgow Provan) (SNP): Thank you all for coming to talk to us this morning.

We have a number of indicators here on where you are against target, and that is fine, but I am more interested in what sits behind that—what process improvement processes you have in place; for any one of those indicators, what your understanding is of what causes the number to be where it is; what action plans you have sitting behind that to drive improvement; and where your trends are over time. Are you understanding the mechanism, implementing the actions and seeing improvements in numbers? Do you have that mechanism clear in your own heads? Could you also say a bit about what you are doing to learn from other boards that may have a better performance? I understand that there are obviously differences in terms of population profile and so on, but there will be boards that are making progress in other areas. Are you learning from that and what is the mechanism for doing so? We will start with that and see how we get on.

John Burns (NHS Ayrshire and Arran): I will kick off. Improvement is fundamental to the work that we do in Ayrshire. We have a strong ethos around learning. The indicators that we report on are indicators of that performance and they therefore cause us to scrutinise and challenge where that performance is not achieving the desired goal. Importantly, they cause us to understand what we can do to improve that through action plans. It can be difficult because of the workforce challenges that we face in putting some of that improvement into action, but we are very clear as a board that we need to have a continuous improvement philosophy that is focused on delivering the best we can.

We use data a lot to look at trends. We look at the data over time and we understand what our data is telling us. That is fundamentally important. We know across a whole range of indicators that we report on how we are performing as an organisation. We look at hospital standardised mortality ratio data and infection control data over time, to make sure that we see that continuous improvement, and we monitor that against all the data points.

We learn from other boards by engaging regionally. There is a stronger basis for that now with our focus on regional delivery planning and working in that regional context, but we also work across NHS Scotland. There have been some very good examples of collaborative working in NHS Scotland. That is a strong way to learn and share best practice. We seek to understand who is doing something in a way that is delivering improvement that we may not be. I think that we can do more of that at NHS Ayrshire and Arran, and we can keep looking. I would suggest looking beyond the traditional boundaries—beyond Scotland even—to see who is delivering transformative change that could help us to improve our performance against targets.

Ivan McKee: Could you give me some specific examples? Just pick one or two indicators and drill down and tell me, "Right, to fix this we have done this, this and this, and this is what it has done", or, "We have learned such and such from somebody else," or, "We have a challenge here, and these are a number of things that we are implementing at ground level to drive some improvement now."

John Burns: I will pick infection control. We have been focused very much on the Clostridium difficile target for a number of years in Ayrshire. We held a summit about 18 months ago at which we brought in clinical leads, because we were not making the improvements that we wanted to see; there was improvement, but not at the pace we wanted. That renewed focus has led to us delivering on the national target for C difficile in the last financial year. That is a very good example of looking at trends and taking action.

The other area that I would pick out is unscheduled care, which is an example of where we have looked to bring improvements by learning from other systems and working with national colleagues. We have delivered change in our unscheduled care programme through increasing our activity at the front door in terms of senior decision making, introducing combined assessment units to bring a different support into our front-door services, and trying to support people to return home earlier. We have seen significant improvement in unscheduled care on the back of combined assessment units. Those are two examples that I would highlight.

Ivan McKee: With C difficile, what did you actually do? What changed in the operation that made the result different?

John Burns: What changed was that, having had discussions over many years with clinical colleagues, we created a focus. We held a summit for clinical colleagues to come and be immersed in a discussion with a clear focus on what further improvement we could make. We worked with Health Protection Scotland and took learning and suggestions, and we were then very clear about the delivery plan and our implementation of that. We then monitored the delivery of that, and we had a very active engagement in that delivery through our infection control team.

Ivan McKee: What did people working on the wards actually do differently? Getting everyone in a room and having a summit does not fix anything. What did people working on the wards do differently that caused that number to get better?

John Burns: In some cases, it is difficult to pinpoint exact actions, but there is no doubt that there was a stronger leadership in the work that we were doing. Our infection control team worked even more closely with our ward teams. We were ensuring—and I think that this is important—that the implementation and delivery plan was rigorously scrutinised and monitored through the infection control committee, and making sure that our systems and processes were as tight as they could be and that everyone understood what they were required to do. There was no one specific thing. I think that there was a range of issues that we brought into that plan that allowed us to deliver that improvement.

Ivan McKee: To flip it on its head, if I am somebody working in a ward and I have a good idea about how I can make things better by doing this, or I know that doing that would improve whatever—and there will be a wealth of knowledge among people who are working on the front line—what is the process whereby that gets translated into action that you take that makes things better?

John Burns: There are a number of ways. First, we encourage everyone to openly discuss things that they think can improve, and if they think they can do it in their local team, to work within that team and do it. Secondly, if they think that it is a bigger issue, we encourage them to raise it with the appropriate line manager, and for that line manager to then work with that team to develop that improvement and to help to enable that to be introduced and progressed. One of the things that we have introduced recently is a staff suggestion scheme. Not everything can be done in the local context, and indeed, some colleagues will have ideas that go beyond their areas of responsibility. We encourage our staff across Ayrshire to share their ideas for improvement, because it is through our staff that we will find those areas where further improvement can take place.

Ivan McKee: Finally, we have Harry Burns in later to talk about his review of indicators: do you have any observations or any comments on that? Are we measuring the right things? Are we measuring the wrong things? Should we be doing it differently?

John Burns: I think that indicators and targets have served us well. They should always be kept under review, and Sir Harry's report is welcome in terms of some of the challenge that he provides by thinking beyond where we are. As we work increasingly on an integrated health and social care space and arrangements, thinking about outcomes and how we measure outcomes in an integrated way will be important for the future. There are targets and indicators that continue to set a strong purpose. If I remember Sir Harry's report, he says that the accident and emergency target is still a valuable target, not as an A and E indicator but as a whole-system indicator. I would agree with that. I think that it is a helpful challenge and we should be looking to progress and constantly keep indicators and targets under review and move as we can to focus on outcomes.

10:15

Ivan McKee: Thank you.

The Convener: Are you still not meeting the C diff target?

John Burns: We met the target in the last financial year.

The Convener: According to the performance standards that we have here, that does not appear to be the case. The current target is 60 and the current value is 64.

John Burns: Yes, in the current year, against the current measures, we have seen a slight movement, but we continue to keep that under review and we are still confident that we can maintain our performance here.

The Convener: Have you met the target?

John Burns: In the last financial year, we met the target in terms of the end-of-year HEAT—health improvement, efficiency, access to treatment and treatment—measurement. In terms of our in-year performance—I think that that is the data that you are referring to—we are slightly above our local target at this time.

The Convener: Mr McKee asked you about specific actions that had been taken to improve that, but you could not really tell us what those specific actions are. How can your board help others to learn if you cannot tell us what those specific actions were?

John Burns: I do not have the specific details at my fingertips. I would be happy to provide those for the committee.

The Convener: Yes.

Does anyone else want to come in on any of the performance standards issues? We may come back to that then.

Before I bring in Colin Smyth, I want to ask about the areas in the performance standards where red alerts are shown. For example, you are not meeting the targets for the treatment time guarantee, the 18-week referral to treatment time and general practitioner appointment booking. What is your response to those issues where performance looks pretty poor? For example, performance on the 12-week treatment time guarantee is 20 per cent below what it should be, and performance on the 18-week referral to

treatment time is 15 per cent below. What is your response to that and how are you going to address it?

John Burns: On the 18-week referral to treatment time, we have a detailed demand capacity model, so we understand what we need to do. We have some challenges in the system to do with the workforce.

The Convener: What does "detailed demand capacity" mean?

John Burns: We have looked at the referrals that we receive in each of our specialties, we have looked at the capacity that we have in our clinics and in our workforce, and we have tried to match those and to understand whether we are able to meet those referrals and that activity coming through the system.

The Convener: Is that about recruitment then?

John Burns: Some of it is about recruitment, and that is why we have had to bring in some locum staff. Some of it is about capacity, and we are looking to adjust our capacity. For example, we are looking at new appointments versus return appointments and working with our clinical teams to see whether there is a way to rebalance some of that activity. We know that there is evidence that not all return appointments have to involve someone attending hospital, so we are looking to redesign to improve our capacity where we can. This year, we are looking to reduce our review attendances by about 7,500 reviews and convert that into approximately 3,000 new attendances. That tends to be the broad ratio that we would see in Ayrshire.

We are trying to enhance our capacity for out-patients. We have access funds from the Scottish Government that we are using to impact and reduce the out-patient waiting times. We have made considerable changes in the past year, but I agree that it is an area that requires further work, and we continue to keep that under very close review.

The issue with the treatment time guarantee is primarily around orthopaedics. There are one or two other areas that we are addressing, but orthopaedics is the main one. We are bringing waiting times down gradually over time as we try to put more elective capacity into our orthopaedic service.

The Convener: So that we do not dwell on this, it might be helpful if, for each of those, you could write to the committee giving us an indication of what action is on-going to improve it and what improvement you expect because of that action. Is that okay?

John Burns: Yes, I am happy to do that.

Colin Smyth (South Scotland) (Lab): I will follow that up with a specific question about one particular performance indicator. What explanation can you give for the fact that NHS Ayrshire and Arran's performance against the 62-day target for cancer referrals has fallen from 92.8 per cent between January and March 2017 to 88.5 per cent from April to June 2017? What was the reason for that fall, and what action have you taken to improve on that target?

John Burns: The main issue that we face is diagnostic capacity. We work with other boards such as NHS Greater Glasgow and Clyde as well as with our own diagnostic teams. We know that in Ayrshire we have radiology challenges, particularly around computed tomography scanning, and that is predominantly a workforce issue of radiology vacancies. We keep that under very close review, because cancer is an area in which we strive to ensure that we are managing referrals, diagnostics and treatment as effectively as we can. We are very much focused on trying to improve that area.

Colin Smyth: You said that you have an issue with diagnostic capacity. Is that to do with staffing problems?

John Burns: We have consultant radiology vacancies, so reporting capacity is a challenge for us. However, we work very closely with our radiology team to ensure that we are prioritising and focusing in on cancer services, and we will be looking to do everything that we can to make sure that that figure improves.

Colin Smyth: One thing you have not mentioned is the board's review of chemotherapy services. You started that review in 2014, and you said that you would carry out an options appraisal in 2015. What exactly have you been doing for the past two years? I have looked through the health board's papers for the past two years and I cannot find that mentioned anywhere. I cannot find it mentioned on the website, apart from the 2015 options appraisal. Why is it being trickled out that you are currently considering the closure of chemotherapy services at University hospital Ayr? Why is that not in the public domain, and what exactly have you been doing since you started that review?

John Burns: As you said, we did a detailed options appraisal, which involved staff, users and other interested groups. Once that was concluded there was consideration of whether there would be a significant service change. We worked with the Scottish health council in order to come to a view on that. We were asked to do a transport impact study, which we did, and that took a bit of time. Having done all that, we got to a point where it was agreed that it was not a significant service change.

I accept that that has taken a long time, but I want to clarify that it has not impacted on the service that we deliver. We are delivering our chemotherapy services in Ayrshire, and I would say that we are doing that highly effectively.

We are now considering work that has taken place in the west of Scotland around systemic anticancer treatment work. We are taking account of that because it gives some opportunities to look at the model for Ayrshire. We will be continuing to have a discussion with staff and patients in the months ahead. We will take our full paper to a public board meeting in January, setting out a model of service, and in the spring we intend to consult on those proposals widely across Ayrshire.

Colin Smyth: Why has none of that information been in the public domain? You mentioned a transport appraisal—that is the first that I knew about that. You talked about the options appraisal. We still do not know exactly what those options are, apart from what has been trickled out. Why is that not being carried out in the public domain so that the public can actually have their say on it?

John Burns: We have worked with our staff and users of the service. What we have not done is formally consult on any change. We realise that we need to review our chemotherapy services and how we deliver them. We want to deliver the best services to our residents in Ayrshire, and we believe that, given the further work that is being done, it would be wrong to consult on what we have done. We should bring into the consideration the wider learning from that west of Scotland work, review our proposition and consult on a revised paper.

Colin Smyth: At the moment, the public perception is that you are going to centralise chemotherapy services on a single site in Ayrshire. Are you saying that that is currently under review and that it might not be the proposal that you bring to the board in January?

John Burns: What I am saying is that we will bring proposals to the board in January that will be built on the best evidence available for delivering chemotherapy services to our residents in a safe way, and we will take account of all of the evidence. It would be premature at this stage for me to say what that final proposition will look like.

The Convener: You said that the performance was good, yet it has fallen from 92 per cent to 83 per cent. Does that reflect a good performance?

John Burns: I would draw a distinction. I am not saying that that is a good performance on the 62-day target, which is for diagnosis and treatment. We need to do much better. Looking at the trend data in Ayrshire, we see that we have had very good performance on cancer. We continue to have very good performance on the 31-day target for delivering treatment once there is diagnosis. Chemotherapy is the next stage in treatment and I believe that we deliver that service very effectively. However, we need to keep all services under review to make sure that we deliver them safely and according to the best evidence.

The Convener: You said that you want to do better. What will you do, and, given what Colin Smyth said about other changes seeming to take a long time, how long will it take?

John Burns: Over time, our cancer performance has been good, and we will do everything that we can to quickly get back to that standard. We recognise the importance of that.

The Convener: What I am hearing repeatedly, and what Ivan McKee was hearing, is a lot of words. What we need to know is what practically you are going to do. If any of the other panellists would like to comment on any of this, they should feel free. What practical steps will you take?

John Burns: We need to address the capacity issue, the reporting issues—

The Convener: What does that mean?

John Burns: I do not have that answer in terms of the specifics. We have been very aware of the drop in performance, which is a recent issue, and we are looking at what action we can take to improve it.

Brian Whittle (South Scotland) (Con): In the recent annual review there was quite a strong cry for public consultation on the delivery of care and chemotherapy treatment in Ayrshire. You seemed to be quite open to that idea. Are we still in that position?

John Burns: Absolutely. The paper that we take to the board will seek approval for formal and public consultation, and we will do that in a public board meeting.

Brian Whittle: Just to clarify, that will not be a consultation with selected members of the public; it will be an open public consultation.

John Burns: Yes.

The Convener: Just for the record, it appears that in the past two years the cancer target has been met only in one month.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): Good morning, panel. My question is on recruitment and retention. NHS Ayrshire and Arran has a higher whole-time equivalent consultant vacancy rate than the national rate. In June 2017, it was 16 per cent, whereas the national rate was 8.5 per cent. In written evidence to the committee, Parkinson's UK in Scotland stated:

"There is a critical shortage of consultants in medicine for older people in Ayrshire, with nearly half (47.6%) of posts vacant."

Why is the consultant vacancy rate higher in Ayrshire and Arran? What is going on? What are you doing to attract people to work in Ayrshire and Arran? Are there any specific things that you have been doing? I know, for example, that NHS Fife goes across to Ireland and does recruitment drives. What kind of things are you doing to attract people in to fill those vacancies?

10:30

John Burns: We are seeking to address the consultant vacancy issue in medicine for the elderly. We have recently recruited into our older people's services a new consultant with a particular focus on acute care, which we think is an important step. We are also redesigning the team around the consultant. We are looking to bring in practitioners in acute care of the elderly to support the medical team and deliver that service. It is about change. We are also looking at how we deliver our older people's services to ensure that we are delivering a service that is modern and will attract consultants to come and work in Ayrshire.

In terms of attractiveness, across all consultant vacancies we are looking first to promote Ayrshire, because we think that it is a good place in which to work and live. Secondly, we are looking to engage in any national recruitment initiatives, and we are looking to learn from other boards, which, as you say, have been looking beyond our shores for recruitment. We are looking to learn from their experience to see whether there are different things that we can do to attract consultants to Ayrshire, because it is a critical and significant issue for us.

Tim Eltringham (South Ayrshire Health and Social Care Partnership): I will come in to give John Burns a rest. He mentioned acute care of the elderly—ACE—practitioners. In recognition that it has proved difficult to attract a full complement of geriatricians, in collaboration with the partnerships and our acute colleagues we have sought to recruit a number of those practitioners, who are, in essence, senior nursing and allied health professional staff with additional skills, who can fulfil a number of roles in prevention and support at the front end of the hospital. John Burns mentioned a combined assessment unit, and such practitioners work in that to prevent admission to hospital after initial assessment and to support discharge, working hand in glove with social work and senior clinical staff. We have sought to recognise the difficulties in recruitment and adapt where appropriate. As John said, we are fortunate to have recently attracted a consultant to come and work with us. There are still vacancies, but we are making progress on that.

Dr Cheyne: One of the other things to recognise is that there is some increasingly clear evidence, albeit that it is anecdotal at this stage, that young consultants prefer to live and work in the central belt. Attracting them to go down to rural Ayrshire is becoming an increasing problem.

Jenny Gilruth: I appreciate that. I represent a constituency in Fife, and I recognise that it is difficult to get people, particularly young graduates, into these areas sometimes.

You alluded to geriatric medicine. The statistics show that more than half of the consultant posts for geriatric medicine were vacant and had been vacant for six months or longer. Is that pattern changing? If you have job vacancies sitting there for six months it suggests that there has not been a culture shift. I appreciate that you are trying to put things in place. That was June 2017. Have things improved in the past six months?

John Burns: Yes. Things have improved, in that we have recruited a very good consultant as clinical leader for the service, and we have worked very hard with our health and social care partnerships to redesign our older people's services so that we are clear about the focus on community and front-door assessment. We have a very different model to offer, which I think will be attractive to consultants. We know that when we can bring potential candidates to Ayrshire and when they meet the clinical team and other teams, they like what they see and hear about Ayrshire and then are keen to follow through on their application.

Alex Cole-Hamilton: I will come on to the issue of delayed discharge in a minute, but I have a couple of follow-ups, the first of which is on Colin Smyth's question about cancer waiting times. We have learned in recent weeks that, in NHS Lothian in particular, there has been a culture of underreporting of waiting times, delays and missed indicators. That has happened at St John's hospital and, as we have heard in the past 24 hours, at the Royal infirmary of Edinburgh and the Royal hospital for sick children. Do you have 100 per cent confidence in the fidelity of the statistics that we have before us today?

John Burns: Yes.

Alex Cole-Hamilton: Very good.

Secondly, I will pick up on Ivan McKee's question about improvement. You talked about diagnostic capacity being a principal reason for delays in cancer waiting times. Right across all of the indicators that you have given us, do you routinely capture the reasons for those delays?

John Burns: Yes, and we report them through our reports to the board at every public board meeting.

Alex Cole-Hamilton: When you have that risk register, as it were, showing the reasons and the catalysts for the delays, is there a follow-up process in which you talk about how to mitigate those specific reasons?

Dr Cheyne: On the governance side, the answer to that is yes. We ensure through the healthcare governance committee, which then reports to the board, that there are quality improvement plans or improvement plans in place to mitigate any such issues. I argue that there is a high degree of scrutiny through the healthcare governance committee, and then reporting that to the board. Uniquely, we have a slightly different set-up after that. The chairs of all the governance committees meet as a group, which is called the integrated governance committee, where we further look at the key issues of the period.

Alex Cole-Hamilton: Convener, are you happy for me to come in on delayed discharge now?

The Convener: Not just now. We were trying to stick to retention and recruitment, so that was a bit cheeky, Alex.

Emma Harper wants to come in on retention and recruitment.

Emma Harper (South Scotland) (SNP): Yes, convener, it is a recruitment question. Last week, Jason Leitch talked about how he works at NHS Greater Glasgow and Clyde but spends a day doing clinic and a day doing surgery in Oban. I am aware that urologists from Ayrshire and Arran also support NHS Dumfries and Galloway, and that the same happens with people from Glasgow's ear, nose and throat service. Are enough opportunities being explored to share skills across boards? If we cannot recruit for a specific area, can we get people out for two or three days at a time over a month or whatever?

John Burns: We need to think more about that type of arrangement. Regional working and regional delivery will give us a chance to do more of that, but we are already doing some of it in Ayrshire in limited ways. We are also looking to work with neighbouring health boards, and you have just given some examples where we are assisting boards. We work closely with Lanarkshire and Glasgow, which provide support for us with service delivery to help to meet some of the challenges that we face, but that is not always a practical solution.

Derek Lindsay (NHS Ayrshire and Arran): I can give a couple of examples. Consultants come from Glasgow for neurology and neurological rehabilitation services where we do not have our own consultants. We have shared arrangements with NHS Lanarkshire for support of the hyperacute stroke unit, which is at University hospital Crosshouse. Those are examples of our working with neighbouring boards, so we have been able to achieve that.

I also want to make a point about skills mix. We mentioned the challenge with consultant radiologists. We have had vacancies for a long period, so we had to consider how to redesign those services. We have trained a significant number of radiographers, who can do a proportion of the work that radiologists would otherwise have done. That is an example of redesign and skills-mix change.

Emma Harper: The national PAC—picture archiving and communication—system for radiography means that a radiographer can take X-rays and then those could be interpreted by somebody in another board, on a Saturday night at midnight, for instance. Does that work happen as well?

John Burns: The PAC system allows images to be shared. On the back of the national shared services work to improve that radiology activity, we need to have a common radiology information system to then allow those reports to be transferred back. That is part of a national programme, and we are involved in it.

The Convener: In relation to recruitment, when there is a vacancy in Ayrshire and Arran, what happens? How does that get advertised, or how is someone recruited?

John Burns: For all vacancies, the department needs to consider whether there should be a straight replacement. There is a natural review of the job and, if it is to be a straight replacement, we would advertise the post.

The Convener: Where is it advertised?

John Burns: We would advertise all posts on the SHOW—Scotland's health on the web—website.

The Convener: Do you do anything more inventive or creative than that?

John Burns: The area where we need to be more creative is the medical workforce, which members have touched on. We continue to be able to recruit to nursing posts, allied health professional posts and others reasonably well. The area that is most challenging for us is the medical workforce, and that is where we are trying to look in different ways and learn from others to see whether we can embrace some of their work.

The Convener: What good examples could you give us?

Derek Lindsay: An example from nursing is that we work closely with the University of the West of Scotland, which does nurse training. A high proportion of the people who go through the University of the West of Scotland nurse training end up working for us, so that is a good link and a feeder system for nursing.

We have tried a number of things on the medical workforce, one of which is using an agency. Rather than bring in a doctor on a short-term basis, we ask an agency to try to recruit for a shortage area. That has had limited impact. Those are a couple of examples.

The Convener: Our briefing paper mentions big waits for those who have musculoskeletal complaints, for example. Are you doing anything creative, inventive or different to get professionals in that discipline?

Dr Cheyne: I will pick up that one, just to try to give John Burns a bit of a rest.

The board recognised and picked up that issue several months ago, although I forget which meeting it was discussed at. The whole musculoskeletal unit has been redesigned over the period since then, and performance is improving significantly. John Burns can give you the latest figures, as I do not have them to hand. The healthcare governance committee recognised that the MSK unit was underperforming—indeed, the unit itself recognised that—so there has been a full redesign and outcomes are now significantly better.

The Convener: You refer to the fact that financial constraints have been at the core of the issue, and that waiting times are increasing because of those constraints. Does that mean that you are not able to recruit staff?

Tim Eltringham: We noted that there has been improvement in the MSK service in one board. I can report that the trajectory is that, probably by March next year, we expect to carry out 90 per cent of treatments within four weeks. We noted that, to achieve some targets on savings and efficiencies, there are potential risks in due course. However, in the interim, we have agreed not to seek to apply the same level of efficiency to the MSK service. Having undertaken the redesign, we have seen significant improvement. Next week, the board will see that we are now at 50 per cent achievement of the four-week target. I think that the issue is about future risk rather than the actuality.

The Convener: Were vacancies not filled because of financial constraints? That is what is referred to in our briefing paper.

Tim Eltringham: There have been occasions on which we have sought to reduce spend by not filling all vacancies, but we agreed at the end of the day that that was counterproductive.

Alison Johnstone (Lothian) (Green): We are aware that you have had a consistently high rate of emergency admissions and that, during the past five years, you have had the highest rate of emergency admissions of all 14 territorial health boards. I appreciate that you have an older than average population, high levels of smoking, obesity and drug and alcohol use and low levels of physical activity and wellbeing. I understand that you have a lot of challenges that may lead to initial admissions, but you also have particularly high levels of multiple admissions, which is when people return three or four times. Why might that be the case?

10:45

John Burns: As you have described, we have a range of challenges around the health needs of our population. One area where we need to do more work is multiple readmissions. We have high levels of chronic conditions in Ayrshire and, from the data, there is no doubt that that is a driver of those multiple admissions. Tim Eltringham might want to say a bit more about technology-enabled care. There is strong evidence that, if we can use digital technology, we can support individuals to have more ownership of their health, using home health monitoring, for example. There is quite a bit of opportunity for us to work more closely with those with chronic conditions and to see how we can support them to manage their healthcare differently to avoid multiple hospital admissions.

Alison Johnstone: Obviously, having support at home is absolutely key to preventing admission in the first place and to ensuring a swift recovery when patients return home. Is there any link between multiple admissions and the fact that NHS Ayrshire and Arran has among the shortest stays of any health board in Scotland? Are your patients leaving hospital too quickly?

John Burns: There is no evidence that patients are leaving hospital too quickly. We have looked at readmissions carefully and, as I have described, there is often an element to do with chronic conditions and exacerbation of a condition. The nature of multimorbidity often causes people to be admitted for a different reason. We continue to look closely at readmissions, because we recognise that they are a measure of how we manage care in our hospital system, but there is nothing to suggest that people are being discharged too early.

Alison Johnstone: You will be expecting increased admissions over the winter period. What measures do you have in place to deal with that expected increase?

John Burns: The partnerships have a range of measures, which Tim Eltringham might touch on in a moment. In the hospital service, particularly around University hospital Crosshouse, we have made a lot of changes. Our combined assessment units are a key part and provide turnaround—that term is never a good way to describe the process but, in managing the care of individuals, those units have quite high levels of success in returning people home and avoiding admission.

To refer back to the older people's physician who we have just recruited, we are going to introduce an extension to that assessment unit process with, I think, 12 extra assessment beds specifically for older people. That will give the new consultant and those practitioners that we have described the space to provide rapid assessment and to seek to avoid unnecessary admission to hospital. That is an important aspect.

Tim Eltringham might like to talk about some of the work that the partnerships are doing.

Tim Eltringham: I can do that at two or three levels. I will also respond to the earlier query about supporting people at home and the issue of self-management.

On the issues about winter and delayed discharges, at the end of the day, we need to work with local communities and individuals to assist them with self-care. For example, John Burns mentioned the work that we are doing on home and mobile health monitoring, which is about the use of technology to enable people to self-care. There is also anticipatory care activity with general practitioner practices, through which we seek to use a variety of indicators to enable a multidisciplinary team meeting in the GP practice. That includes social work and other staff, who aim to identify people early who may need support.

Clearly, there are certain circumstances and we have not cracked the issue of people turning up at hospital more frequently than happens in other localities. Obviously, we need to manage that demand as effectively as possible. From our perspective in South Ayrshire—and, I imagine, that of my colleagues in North Ayrshire—we have concerns about delayed discharge, because that impacts on the system's ability to manage demand. A significant strand of our winter planning involves trying to identify additional capacity for home care, which is where we struggle most in South Ayrshire.

On the earlier questions about recruitment and retention, two or three weeks ago, we held a job fair seeking to attract as many people as possible to work as home carers in South Ayrshire. We have been able to speed up appropriately the process of recruitment, and a number of people are already in induction this week and next. We have also sought additional capacity from our private providers. We have put out a further contract to tender, and I am hopeful that a provider will start to provide additional capacity in January.

Over and above that, we have a range of initiatives and activities that are designed to support people to return home as quickly as possible. We have capacity issues in home care and care homes. Our care homes, which are largely in the private sector, are mainly running at almost 100 per cent capacity. Obviously, our objective is to maintain people in their own homes.

There is a range of activity. One area that I have not mentioned is the intermediate care team. Most partnerships have multidisciplinary team working involving allied health professionals and social workers working in hospitals to support discharge and minimise admission. There is a range of activities for the winter.

Dr Cheyne: Tim Eltringham rightly talked about South Ayrshire but, to complement that, I point out that North Ayrshire is also carrying out that process and has recruited additional resource. I think that it has taken on 20 or 21 additional people for home care, which will help to address the problems in the north.

Alex Cole-Hamilton: Moving on, we know from our meeting with the Royal College of Emergency Medicine that delayed discharge is often the principal cause of delays in A and E. In fact, it interrupts the flow in the healthcare journey. What are the barriers to social care in your territorial areas that are causing problems with getting people out of hospital, and what are you doing to mitigate them?

Tim Eltringham: At the moment, there are two main issues for us, the first of which is capacity downstream in care homes. Year on year, there has been an increase in the number of care home placements that we are funding. Obviously, we have a good relationship with all the providers in South Ayrshire, and we work hand in glove with them to manage capacity and demand as best we can, but the homes are, by and large, full. It had certainly been our strategic ambition to try to manage down the number of people ending up in care homes, and in certain circumstances, if we are able to intervene more quickly, we can prevent deterioration. After all, there is good evidence to suggest that if older people stay in hospital any longer than 72 hours or so, the risk of their ending up in a care home is higher.

To some extent, our ability to achieve the ambition of speeding up people's discharge has been a consequence of our inability to provide home care timeously. As I said in response to an earlier question, we are seeking to increase our home care capacity and to manage it more

effectively. For example, we have introduced a reablement service. We were asked earlier about learning between partnerships, and I think that there has been good learning across Scotland on this issue. Instead of people being helped with bathing, going to the toilet or whatever, reablement is a way of supporting them early in their time in home care with a view to helping them to do those things for themselves and, as a result, to need less from the service. However, we have introduced reablement only recently, and we still need to see its full effects.

In this respect, there are two issues for us: using our home care capacity more effectively and adding to total home care capacity. In thinking strategically with regard to our commissioning plans, we need a better understanding of the data on the local population, particularly that in South Ayrshire, where the demographic characteristics are quite unusual. I think we are beginning to establish that there is relatively high deprivation, but there are also relatively high numbers of older people as well as a much smaller group of people of working age. As a result, the dependency ratio in South Ayrshire is very high.

As we begin to reflect on what we do with the entire system, I should point out that delayed discharge is simply a symptom of the system not working in the way that we want it to. What we want to do as we look at commissioning is to understand what the future demands are likely to be and manage our service in that way.

Alex Cole-Hamilton: I fully understand that, and I think that the situation you have described is replicated across all 14 health boards, particularly with regard to residential care capacity. With home care, however, I am always struck by the tension that, even with integration, still exists between the willingness of a health board to spend £400 to £500 a night on keeping somebody in hospital and the social care directorate's unwillingness to spend £150 a day or night on care at home. Are you familiar with that tension? Is that the reality? Secondly, is there a capacity issue with regard to recruiting and retaining social care workers and being able to provide that care on the ground?

Tim Eltringham: I will deal with the second issue first and then move on to the first.

Yes, recruitment is an issue. However, at the recent job fair that we held, we were pleasantly surprised to find so many people coming forward to work in what is effectively our in-house, council-managed service. Of course, the risk is that we attract applicants from the private sector. We know that that is happening, but all you are doing is moving capacity from one place to another.

However, that is not the only issue. We will not be unusual as a partnership in feeling this, but perhaps some of our thinking needs to change. Communities and families will need to do much more to support people, and using the assets of communities in that wider sense will be very much at the forefront of what health and social care partnerships will want to do. With some of the traditional models, we are simply not going to have the bodies to do the work. I accept that, and obviously we, like other partnerships, will continue to monitor that situation.

I think that your point about resourcing beds rather than care home places or care at home is understood, and we have made progress in that respect. For instance, we undertook some quite significant demand-and-capacity work in one of the community hospitals in South Ayrshire. We looked at the role and function of such hospitals, particularly in light of the fact that NHS continuing healthcare does not really exist any more, and found that their best function was the palliative and rehabilitative capacity that they provided. As a consequence, we have closed a ward in the hospital and used those resources for care at home and care home provision.

John Burns and Derek Lindsay might wish to come in on this, but the issue becomes more difficult with regard to acute hospital care, because I do not think that it is easy simply to take those resources out and move them to social care. Where possible, however, such changes can be made.

11:00

Alex Cole-Hamilton: Does anyone else want to comment?

John Burns: I think that Tim Eltringham makes a good point about the work done in the community. However, the issue is more difficult when you look at acute care. As has been mentioned, the levels of need in Ayrshire are high, and what we are striving to do with our partnerships is to manage that need and to bring down demand. If, as things evolve and strategic plans develop, we start to see a substantive shift from hospitals to community provision, we can start to address that issue, but the risks and demands in managing acute care just now are so great that we are not in a position to have that discussion about shifting provision from acute hospitals to partnerships.

The Convener: Are you saying, then, that the whole financial premise on which integration is based of moving money from acute settings into the community is not realistic and is not happening or will not happen—or will not happen without transitional cash?

John Burns: I am probably saying two things. First—and I am talking about Ayrshire here—we

need to stabilise the acute system. We also need to transform how we work and how we deliver care.

The Convener: What does that mean?

John Burns: When we look at population need, we try to identify that need with our partnerships and work together across the entire Ayrshire system to understand what changes can be made. We have already touched on certain changes around technology and the use of digital to help support individuals in their home. However, given the demands, I do not see at this point any opportunity to shift money from acute hospital provision into community provision.

One of the challenges that we face as we go forward is to make sure that the strategic planning for which partnerships are responsible looks very closely at demand and if over time we can see that shift, we will respond accordingly. That said, I do not see that as something that will happen immediately and, in any case, anything that we do needs to be risk assessed, because destabilising the acute system will put too much risk into patient care.

As for your second point around transformational funds, we have the integrated care fund, which provides some of that transformational opportunity. Ayrshire is developing a transformational plan, and I think that we will need some transformational funds in order to make that step change to community provision, because you need robust and resilient community services in place before you can consider such shifts.

Dr Cheyne: As a rider to that, I think that the chief executive has made the point clearly, but I want to emphasise that the chairs group, too, has made a very similar point about transformational change. Transformational change will happen effectively only when sufficient resource is put in place to support it.

The Convener: And is that the common view of the chairs of all the boards?

Dr Cheyne: Yes.

The Convener: If nobody else wants to come in on delayed discharge issues, I call Emma Harper.

Emma Harper: I will focus a wee bit on complaints and complaints procedures. Last week, Tracey Gillies, who is NHS Lothian's chief medical officer, talked about patient experience, and poor experience is what leads to complaints. I know that we have implemented changes in the complaints procedure so that feedback is more of a focus. There are complaints, concerns, comments and even compliments now and again.

I am looking at your complaints document, the "NHS Ayrshire & Arran Patient Experience Annual Report 2016-2017", which talks about things that you have put in place, such as what matters to you, the compassionate connections programme, and different ways of obtaining feedback. I would be interested to hear your thoughts about why the target response time of 20 working days is not being met. I am just reading that one reason is that complainants are requesting face-to-face meetings, which can be a challenge for diaries and bookings.

John Burns: Before the new complaints procedure was brought into being, Ayrshire had been reviewing its complaints processes. We wanted to be more responsive to patients, so we introduced the fundamental premise that, wherever someone complains, we should afford them the opportunity of a meeting if that is what they wish. The evidence showed very clearly that, if we enabled a face-to-face discussion with the individual and staff, there was a greater chance of resolution for the individual and learning for the team.

That leads to two things in relation to the 20-day target. First, it is important that any discussion takes place at a time that is appropriate for the complainant or their family and that we do not rush it just to meet a deadline. It can be challenging to bring staff in, given their clinical commitments, but we commit to that and we look to do it as quickly as possible. It can contribute to delay, but I believe that, as long as it is done in conjunction with the patient and their family, where that is appropriate and they are happy with that, it is the right thing to do to have that face-to-face conversation.

Secondly, although we should always strive to meet the target and keep the communication going with the complainant, written complaints can often be quite complex, so it can take a bit longer to give a full and comprehensive response to a family or an individual. Again, we would always seek to do that within the target and, if we cannot, to keep the complainant informed so that they are aware of what is going on and when they can expect a response.

Emma Harper: The top five complaint themes are communication, attitude, behaviour, clinical treatment and appointment date. Obviously, there is a range of types of feedback or complaint, right the way up to things such as wrong-site surgery, which is very rare. Looking at communication and attitude, can you tell us a wee bit more about the aspects of complaints that make it difficult to meet the deadlines for the complaint response?

John Burns: The complaints on the communication theme are ones that we would seek to address within 20 days. The ones that take a bit longer are where an individual is

concerned about the clinical care that they have had. There may be a range of issues that mean that we need to speak to a range of professionals to be able to bring together a comprehensive response for that individual. I am very clear that, where we can respond in 20 days, we are absolutely committed to doing so. In areas such as communication, we should be able to do that.

Miles Briggs (Lothian) (Con): One of the areas that you highlighted in the information that you gave to the committee was the higher than average levels of smoking in Ayrshire and Arran: specifically, 22.7 per cent of people there smoke compared with 20.2 per cent nationally. What work is the board doing to increase the uptake of smoking cessation?

John Burns: That is an area that our public health team leads on through the smoking cessation programme, health improvement work—Tim Eltringham might have something to add to this—and local activity to support individuals who want to stop smoking. The smoking cessation programme is the key focus. I do not have the detail with me on the specifics of the programme, but I would be happy to provide that to the committee afterwards.

Tim Eltringham: I have nothing to add to that, although I am happy to provide information afterwards.

Derek Lindsay: An area to mention is nicotine replacement therapy—patches and so forth—which we make available to patients and in-patients.

Miles Briggs: If you could provide us with that detail, it would be helpful.

The Government is continually telling us that the health boards are working towards parity between mental health and physical health. Looking through the information you provided us, I found two paragraphs totalling 119 words outlining many of the problems. Could you outline to us how big an issue mental health is for your board and what work you are doing to deliver parity between the services?

Tim Eltringham: Clearly, mental health and wellbeing is a very significant focus of the work that we are undertaking in the localities in each of the three partnerships in NHS Ayrshire and Arran, but the specifics of what we are doing have gone out of my head for the moment.

Miles Briggs: I looked up your health improvement, efficiency and governance, access and treatment target, which suggests that only 76 per cent of people in June were seen within the 18-week target. What work is going on to try to improve that?

Tim Eltringham: There are probably two issues that are foremost in my mind here. The first is mental health and wellbeing, and the other is the mental health service for people with severe and enduring mental health problems. That is largely led by my colleagues from North Ayrshire. I am not absolutely clear on the achievement of the target at this stage, but we could provide you with some more information after the session, unless John Burns has something now.

John Burns: There are two targets: child and adolescent mental health services; and psychological therapies. Child and adolescent mental health services have been performing above target against the 18-week measure and they have been improving. They are a good example of where integration has worked; it has allowed child and adolescent mental health services to work with other agencies and partners to redesign the work differently in order to contribute to that improvement. We see strength across Ayrshire in that area.

We have been conducting a review of our psychological services. We were concerned at the performance, but we also felt that we needed to review and change the services. That work is under way and the latest figures that I have for psychological therapies, which cover a wide range of interventions, is a performance of 87 per cent. We are seeing a marked improvement in that area. It is still not at target, so there is still work to do.

Tim Eltringham is right to say that mental health and wellbeing is a priority issue in Ayrshire. We know that it is one of those areas that are raised consistently by citizens as an area of concern. There is work going on in the partnerships but, importantly, we have a pan-Ayrshire approach to mental health services. We opened a new in-patient facility recently, which has transformed the in-patient experience for those who require an in-patient stay. We have also been continuing to develop community services. Primary care mental health is a particular area of focus and a continued priority for us.

Tim Eltringham: One of the things that went out of my head earlier was that one of the significant areas of focus for us is in localities where isolation and loneliness have been raised as concerns; clearly, what we look to do there is to work with local people to identify opportunities for people to come together and have social interaction. At a more clinical level, each of the partnerships in NHS Ayrshire and Arran, with funding from the integrated care fund and from the Scottish Government, has put in place community link workers—they will be called different things in other places—who support GP practices to meet

the needs of people who have relatively low-level mental health needs.

11:15

NHS Ayrshire and Arran has recently been rolling out the use of electronic cognitive behavioural therapy for people with relatively low-level mental health issues, encouraging GPs to prescribe—or to refer people on to—that type of online assistance, rather than necessarily pharmaceutical therapies in the first instance. I think there is good evidence from across Scotland that that is likely to improve people's wellbeing overall.

Miles Briggs: I have a very small supplementary. Is every GP in your health board area trained in, and do they have access to, ALISS—a local information system for Scotland—if that is where they are making referrals to?

Tim Eltringham: I assume that you are referring to the directory of services and so on. Each of the partnerships in NHS Ayrshire and Arran—certainly it is the case for us and I think it is for East and North Ayrshires—has been working with each of our voluntary sector/third sector interface organisations to develop more bespoke or more local access directories and so on that fulfil the same function as ALISS. I am not sure whether GPs have direct access to it, but certainly the community link workers are the people who are probably best placed to put people in touch with local services at the more informal and non-statutory level.

Brian Whittle: I should have declared an interest at the start, in that a close family member of mine works in NHS Ayrshire and Arran—apologies for not doing that at the start.

I would like to touch on the reporting of significant adverse events. Forgive me if I have the years slightly out of kilter here, but I think that between 2010 and 2013 there were 54 adverse events reported, so they were running at roughly 18 a year. The totals for the next three years were zero, three and four. That is a significant change. Who monitors the number of significant adverse events and what investigation would those changes initiate?

John Burns: In answering your question, I should probably give a bit of context about adverse event reviews in Ayrshire. We have had a continuous improvement process for significant adverse events in Ayrshire since a review by Healthcare Improvement Scotland in 2012. That is the basis on which we have continued to look to review and learn from our process.

We have different levels in the organisation where adverse event reviews are regularly reviewed and monitored. The first is at the directorate level: in the adverse event review group directors and members of the directorate team have responsibility for reviewing the progress in delivery and improvement around adverse event reviews.

That is then reported through our risk management committee, which I chair. We look at the number of adverse event reviews. We are looking at the learning that comes from adverse event reviews, and that is then reported to the healthcare governance committee. Each significant adverse event review is reported to the healthcare governance committee. The action plan is reported and the committee holds me and my fellow directors to account for delivering that improvement and demonstrating learning. One of the things that we have been developing is the use of learning notes as a way of sharing the learning from adverse events more widely.

Brian Whittle: For there to be such a significant drop in the reporting or the instigation of significant adverse event reviews, there are only two things in my mind that can happen: either you have implemented change that has hugely improved outcomes, which would be fantastic, or you have changed what constitutes an adverse event. Would you like to comment?

John Burns: As part of our review back in 2012-13, we looked very closely at the national definitions of what is categorised as a significant adverse event as opposed to an adverse event. We brought in clarity to Ayrshire around those definitions, and that had an impact on the total number of significant adverse event reviews that were initiated. It also meant that there was an increase in the number of other reviews as part of the wider definition. Everything is recorded through our Datix system, and we are able to look at how all adverse events, however scored and rated, are reviewed and addressed.

In our process, a request for a significant adverse event review would be submitted to the medical or nursing director for a final decision on whether there should be one. Since 2012, we have kept that under review and we continue to keep the definition under review, but we believe that we are working in line with the definitions that exist for significant and other reviews.

Brian Whittle: Would you accept that there is a huge disparity between health boards in terms of the numbers of adverse events or significant adverse events that are reported? That suggests to me there is autonomy within health boards to define "significant adverse event".

John Burns: There is a definition. We would use a scoring method to determine whether an adverse event merited being categorised as

significant. I cannot speak for the other territorial boards, but I assume that they will have similar systems and processes to the ones that we have in Ayrshire.

Brian Whittle: On a related matter, you will know that there was a Healthcare Improvement Scotland review of the neonatal unit in University hospital Crosshouse. One of the outcomes of that was that reading of cardiotocograph monitors is a major contributor to preventing baby deaths. Off the back of that, there seemed to be an indication that mandatory CTG training across the neonatal unit would be implemented twice a year. Will you confirm whether that is the case?

John Burns: The review of the Ayrshire maternity unit has concluded: CTG training was certainly an aspect of that. Our response to that has been to do a full training needs analysis across our maternity services, which includes CTG training, and to introduce, and make sure that we comply with, the recommendations that were brought through in that report, including on CTG training.

Brian Whittle: Is CTG training now mandatory for all neonatal unit workers?

John Burns: CTG training was being done in Ayrshire but, if I recall, the recommendation was about developing further how clinical teams come together and train together. I cannot recall the detail, but I am very happy to provide it for you: I know that we have it.

Brian Whittle: I can help you, if you like. I know that CTG training was available, but the report suggested that it was not being taken up because it was to be done in the private time of healthcare professionals. The recommendation was to make CTG training available during work time and to make twice-yearly training mandatory for all neonatal workers. That is information that I have been given by the cabinet secretary, although I will have to check it. I just want clarification of whether that is actually the case.

John Burns: We are implementing the recommendations: ensuring that all our maternity staff undertake appropriate CTG training is part of that. It will be part of our training needs assessment. We have a suite of mandatory training, and each discipline has its own mandatory training. We are very clear that CTG training needs to be provided for all our maternity staff in Ayrshire.

The Convener: You can clarify whether the position is as Mr Whittle suggests it is or is different?

John Burns: I will clarify the position. I just cannot recall it now.

The Convener: We will need to follow up on a number of things following our exchanges today. We will include that in the list.

On finance, the board is required to deliver "cash-releasing efficiencies", as you would describe them—I would describe them as "cuts"—of £20 million. Will you achieve that?

Derek Lindsay: The target for cash-releasing efficiency savings in the current year is £25 million. There are challenges around that. We have secured about £18 million or £19 million of that—the balance is not yet secured. We talked earlier about the musculoskeletal service and AHP numbers. The planned cash-releasing efficiency savings there have been deferred because of the potential impact on services. In some areas, there is replanning going on around cash-releasing efficiency savings.

The Convener: Audit Scotland identified quite significant unspecified savings. Is it sensible to proceed by just sticking in a number and saying, "We hope to get it somehow"?

Derek Lindsay: Ideally, we would identify the savings in advance of the start of the new year. There is ongoing work in a number of areas—for example, in prescribing. Work this year within individual directorates and teams will identify next year's savings, as they go through the year. It was mentioned earlier that when a vacancy arises, an assessment is carried out to see whether it is necessary to fill it. If it is not, that can contribute to the next year's efficiency savings. Ideally, all savings would be identified before the start of the financial year, but the reality is that we have not been in that position. Some non-recurring savings have been identified that need to recur in future years, so that is a challenge.

The Convener: Our papers say that the revenue plan that has been approved by the board included a £13.2 million deficit that is now projected to be over £20 million. Will you comment on that?

Derek Lindsay: The £13.2 million deficit was projected in our local delivery plan for 2016-17. In 2016-17 there were significant recurring cost pressures related to a change in national insurance contributions, which cost us about £7 million extra. There was about a 10 per cent increase in prescribing cost and we invested in a number of other areas that have been touched on. For example, we invested an extra £1.5 million in radiology to increase capacity, based on demand and capacity analysis. We also identified £3 million extra for nursing, of which £800,000 went into mental health services, £1 million into maternity services and the rest into acute services. We had a very big challenge in 2016-17 and projected that we would have a £13.2 million deficit in that year.

Through non-recurring efficiencies, we were able to get back to a break-even position in 2016-17.

However, in 2017-18 the investments that I mentioned earlier are taking their full cost. At the beginning of the year we projected a deficit of £13.2 million, but things have moved in the wrong direction this year. One of the major reasons for that is the additional unscheduled care beds that we have had to open in both our acute hospitals because of demand. That will increase our overspend by in excess of £6 million. We are projecting a deficit in the current financial year.

11:30

The Convener: According to the performance standards, your target was a £7.5 million deficit. What will it now be?

Derek Lindsay: No—our target was £13.2 million. The figure that you cite may be from phasing and where we would be at a particular point in the year. You are perhaps looking at the figure for September or October, for which we projected overspend of £7.5 million. We expect the final deficit to be about £20 million this year.

The Convener: Okay. What happens then?

Derek Lindsay: We are in discussion with the Scottish Government regarding brokerage, which is a mechanism whereby the Scottish Government would, in effect, lend us money to cover that £20 million deficit. We continue our efforts to address the deficit. We are minimising expenditure where we can without impacting on front-line services. We have a transformation programme that is identifying further cash-releasing efficiency savings. There is ongoing work that is striving to minimise the level of deficit and there is work being done nationally on things including sustainability and value, which is looking at workforce, prescribing, shared services and so on.

Dr Cheyne: I assure the committee that the board looks at those matters in-depth in a number of ways, including board workshops and various other mechanisms. One of our non-executives—the vice-chair—is on the transformation group. We are monitoring the situation in a number of ways with the chief executive and his exec team. On behalf of the board, I can give the assurance that we are working hard to continue to deliver the safe service that we want to deliver within the resources that we have.

The Convener: The question is therefore whether there has been a failure in financial planning or you simply do not have enough money to run the service.

Dr Cheyne: The director of finance has indicated where the areas of financial pressure are for us. Do you want me to reiterate them?

The Convener: No. I am asking the straightforward question whether you have enough money to run the service. It can only be a yes or no.

Dr Cheyne: I will let the chief executive answer that.

The Convener: You are the chairman.

Dr Cheyne: He is the accountable officer for the organisation.

John Burns: I do not think that it is as simple as giving a straight yes or no. What we are clear about is that there are pressures—for example, Derek Lindsay alluded to unscheduled care provision that we needed to change. This is about recognising that we need to address underlying pressures around the medical workforce and unscheduled care. We also understand that because of the demands on our system, we need to redesign and deliver services differently, in a way that delivers better value for the money. That is the case across the whole system. We need to continue to look for best value. It is more difficult than it has ever been, but that is not to say that we should not still be trying to drive through efficiencies and to change where we can. It is not a yes or no question for me: it is very much about what we, as a board, are trying to do to deliver improvement and change while continuing to deliver the service.

Ivan McKee: I have a very brief question. Just to put it all in context, can you tell me how much your budget was in 2016-17 and how much it is in 2017-18?

Derek Lindsay: Our cash-limited budget for 2016-17 is about £680 million, which will increase by about £10 million for 2017-18. Most of that increase is earmarked for social care services, so it is passed across to invest in those.

Ivan McKee: Are you saying that there was, in cash terms, no increase?

Derek Lindsay: There was an increase of about £10 million.

Ash Denham (Edinburgh Eastern) (SNP): I will ask about work on the preventative agenda. Obviously, we know that that is very important, particularly considering the deprivation profile of Ayrshire. We know that if we get preventative spend right it can result in effective savings in the medium term. Your paper says that you intend

"to implement a range of high impact targeted interventions".

What areas have you identified and what programmes are you planning to undertake?

Tim Eltringham: Earlier, I referenced the fact that there are ways of managing long-term

conditions more effectively than we do through self-management, technology and so on in order to prevent people requiring hospital services. Even before that, there is a wide range of activity in which our colleagues in public health and health improvement are supporting the three partnerships. For our purposes in South Ayrshire—I think that it is probably the case in East Ayrshire and North Ayrshire as well—the community planning partnership has a significant role in looking at prevention.

Again, in the South Ayrshire context, I chair a strategic health and wellbeing group. As recently as last week we heard proposals that have been jointly developed by the health and social care partnership and our colleagues in the council's leisure services to develop a healthy-activity programme across the partners. We expect them within the next two or three months to come back with proposals on how each of the contributors to community planning might contribute to active citizenship and so on. There are a number of levels at which we are trying, where possible, to prevent demand, to manage demand more effectively, and to reduce the circumstances in which the state needs to intervene.

I mentioned the work of community link workers in GP practices, which is seeking to get people involved in more informal activities. A specific example is the dementia-friendly towns initiative in Prestwick and Troon, where local people, the locality planning group, businesses and so on are seeking to support people with dementia, and to include them, and to increase and improve their resilience and that of their carers. It seems that those are the sorts of activities that we will need to major on over the coming period in order to reduce demand and manage it more effectively.

Ash Denham: In terms of preventing avoidable illnesses, which illnesses have you identified and what specific interventions regarding them are you planning?

John Burns: I will just make an additional comment. The point about community planning is incredibly important. Across Ayrshire—I sit on all three community planning partnerships—there is a very strong prevention agenda across a wide range of inequality and change. That is important.

We have been talking with our public health team of late about diabetes and the need for a focus on gestational diabetes and on working with and trying to improve type 2 diabetes. We are looking to progress that within our work because we believe that there are significant benefits in the short and longer terms in addressing some of the challenges around diabetes.

My public health colleagues are working on good examples of greening our estate, and we are supporting and encouraging physical activity. We believe that that is key. Again, through community planning, that is a strong feature of our approach.

The Convener: We are well over time, so I thank you very much for coming this morning. It is greatly appreciated. There are a number of things on which we will follow up and correspond with you, and there is some information that you will provide. We will break briefly to change the panel.

11:40

Meeting suspended.

11:44

On resuming—

Health and Social Care Targets and Indicators Review

The Convener: Agenda item 3 is an evidence session on the final report of the expert review group on targets and indicators. I welcome to the committee Professor Sir Harry Burns and invite him to make an opening statement.

Professor Sir Harry Burns: When I was asked to carry out the review, I think that there was an expectation that I would say that certain targets and indicators should be dropped and that others should be brought on board. As I began to tease out the whole issue—not just targets and indicators for waiting times and so on, but the whole landscape of health and social care and the indicators that are already out there—it became pretty clear to me that just dropping some targets and pulling in others would not change anything. I think that it was Einstein who defined insanity as carrying on doing the same thing and expecting different results. It seemed to me that the problem with targets and indicators was not what they were, but how they were or were not being used.

11:45

A number of reports published outwith Scotland confirm the fact that when targets are applied, some change can be seen in how the system works, but very often a problem arises because all the attention is focused on the target and the target is just one slice of activity in a complex system. The length of time for which people wait in an accident and emergency department is determined largely by the number of people coming in and the number of people going out, yet we do not seem to pay too much attention to that. The focus is on whether the 95 per cent target has been met.

My recommendation therefore was that we keep the existing suite of targets—more or less, with one or two alterations—but that we use them not simply for judgment but for continuous improvement in pursuit of an aim. The other thing that I was not clear about was the aim. What is the purpose of health and social care? The only thing that was out there was the Scottish Government's stated purpose, which is to ensure that all of Scotland flourishes through things like inclusive economic growth. If we want a more flourishing, economically prosperous, successful Scotland with low crime, high educational attainment and so on, let us step back and think about what is needed to achieve that and let us put in place targets and indicators; let us primarily put in indicators that will show progress towards that.

One thing that I recommended, which I think is extremely important in pursuing that aim, is the collection of data on adverse childhood experiences. The evidence from a number of international studies, of long duration and large numbers, is very much that if we want a population that is successful educationally and in the jobs market, that has low offending rates and so on, we need to pay close attention to the lives of children living in adverse circumstances. I can go into more detail on that, but advocating the collection of data on adverse childhood experiences is a problem because at the moment we have no system to collect that data. Therefore, I would hope to be able to work with officials to design a system for collecting data and for developing responses to situations where children are living in adverse circumstances.

Those are the main points that I wanted to make. This is about collecting data on processes and outcomes, not just slices of data that tell us where in a process 95 or 85 per cent compliance is being achieved.

The Convener: Thank you very much. A number of members want to focus on the early years issues that you raised and I think that that is appropriate.

A number of people who have followed some of the work that you have been involved in throughout your career initially looked at the review with great interest, but there is a sense of people being underwhelmed by it—the review took quite a long time and we wonder what it is really saying. I think that you expressed that at the start, when you said that people had expectations of what the report would say, but that it has turned out somewhat different. Can you comment on that? Am I wrong to feel a bit disappointed?

Professor Burns: I am quite excited, because there are very few systems in the world that are looking at health and social care as a complex system. It is an opportunity to take things further forward.

If folk thought that I should be advocating that the four-hour A and E target be dropped, they are very much mistaken to think that that would make a significant change. Apart from anything else, the four-hour A and E target at least has some evidence behind it. Let us look at an example using that target. Let us say that there are two hospitals, one of which achieves 95 per cent compliance while the other achieves 85 per cent compliance. Everyone looks at the 85 per cent compliant hospital and says, "Oh, it must be bad." However, if we look at the system, we find that hospital A—the 95 per cent compliant hospital—sees 1,000 patients a week in its A and E department, and hospital B, which achieves 85 per cent compliance, sees 3,000 patients a week in A

and E with only 50 per cent more staff. Which one is more efficient?

We might then look at the next bit of the system and see how many people are being admitted. If hospital B, with the 3,000 patients, is admitting more patients and they are staying longer, that probably tells us that hospital B is seeing sicker patients. However, at the moment we do not collect the data that tells us how hospitals are functioning. The system just looks at the 85 per cent compliance rate and the newspapers go crazy about it.

We have an opportunity to do something rational for a change, rather than just picking numbers out of thin air. I can tell you that the numbers are picked out of thin air, because almost 20 years ago when I was lead clinician for cancer in Scotland, someone came up to me and said, "We want a target for cancer care. Does three months sound about right?" That tends to be how targets were achieved in the past, but we have an opportunity to move beyond that. Either we have the nous—the will to do something quite radical around improving performance in health and social care—or we just want to sit back and say that we will stick with the original targets.

The Convener: But you are sticking with quite a lot of the original targets. You are keeping them.

Professor Burns: Yes, until we have the data that shows that they are influencing outcomes—very few of the targets are to do with outcomes. We do not measure. Again, I return to the four-hour A and E target. The main data that says that four hours is the right time comes from quite a big Australian study, which showed that mortality declined and was at its lowest in the three and a half to four-hour waiting time period and that as patients waited for more than four hours, their subsequent mortality increased. Is that because they waited in the A and E department, or were they in the A and E department getting investigation and resuscitation and therefore they were sicker and were more likely to die? We do not know that. If you were managing a business, you would not manage it with that kind of data.

Ivan McKee: Thank you for coming to talk to us. I share some of the convener's concerns about what has been pulled together in the report. You mentioned business, which is my background. This stuff is second nature in business, because this is what people do.

I think that the process that you start to outline in paragraph 37 of the report makes sense. You need to know your objectives, your outcomes and your key performance indicators and then you set targets. There is a thing about how organisations are aligned so that we have the right people and we know who is responsible for hitting the targets, but that is probably out of scope. There should be a hierarchy of indicators, so that people know which are the important ones, which are secondary, and which are feeding into them; that then drives the improvement plans, which is the whole point.

Earlier this morning we had a session with NHS Ayrshire and Arran about how it is doing that work. That kind of structure makes sense and to my mind it is well understood. I think that you are saying that it is not well understood in the health service and that further work needs to be done to drive that understanding before we even go forward with reviewing the indicators. I think we all thought that we would get to that next.

It comes down to what is measured. You talked about A and E, and you are absolutely right to say that a waiting time might not be the right thing to measure but that there are things such as flow through and demand that should be measured. Perhaps the issue is not that we are not measuring something, but that we are measuring the wrong thing.

Professor Burns: No—if I had thought that we were measuring the wrong thing, I would have said so. It is important to measure the four-hour waiting time, because the evidence that we have points to that. However, we need much more evidence about it.

Ivan McKee: You measure other things as well, perhaps.

Professor Burns: Yes. We need to know what the process is in each hospital. Most businesses are far less complicated than society, because that in effect is what we are looking at here. What drives people into A and E departments? I discovered recently that there is one A and E department that has about 12 people who between them over the past five years have accounted for 2,000 of attendances there. That tells you something about those individuals, and the circumstances in which they are living. The answer lies not in doing something about the A and E department, but in all the other things that can support those individuals. We are looking at an immensely complex system and trying to bite off small chunks of it, and we are not doing the population any service by just narrowing it down in that way.

Ivan McKee: It is complex in one sense, but business problems are complex, too. I suppose the concern I would have is that you are saying, "It is too big and scary, we cannot do anything. Let us not do anything at all."

Professor Burns: No. I am not saying that at all.

Ivan McKee: If that is not what you are saying, what happens next? Who should do what next?

Professor Burns: That is a good question and that is a matter for the folk up the hill.

Ivan McKee: What would you recommend that they do next?

Professor Burns: Over the past few years, with an improvement-based approach to patient safety and the early years, we have seen significant reductions in infection rates and hospital mortality, and significant improvements in the stillbirth rate and infant mortality, by applying a co-production approach in which front-line staff work to see what change indicators they think are important.

The line I have used is that the data should be used for improvement, not for judgment. Instead of creating a blame culture that says, "You guys are obviously useless, because you are achieving only 85 per cent," we should be creating a culture in health and social care partnership areas that says, "What are the drivers of demand? What is preventing people from being sent home so that beds are available?" and all that kind of thing. I do not have much sense that that is being done systematically, because all the focus is on the hard targets that folk know they will get a thick ear for missing.

Ivan McKee: Do you think that there is not an understanding that that culture needs to change?

Professor Burns: There are plenty of folk who understand that that needs to happen, but the focus from the press and from politicians is all on saying, "You have failed." It is the old view in which what is counted is what counts and therefore people put all their attention on the numbers that are being counted rather than on thinking about changing the broader system.

Ivan McKee: Do you think that politicians do not understand that?

Professor Burns: I do not think that politicians do, from the way in which they respond to some of the data.

Ivan McKee: Obviously, the very first part of this is setting your objectives and what you are trying to achieve. Do you think that there is not clarity, at the top, about what we want the system to achieve?

Professor Burns: The report takes the stated purpose of the Scottish Government, which I think has a pretty broad appeal across the political spectrum. That seems to me to be as good as you can get. There are few other countries that have set themselves a purpose in the way that Scotland has done.

Ivan McKee: But it is very broad and top level.

Professor Burns: It is broad, but it has enough in it. There is the notion of a flourishing population—in which the kids do well at school, get into jobs and are creative, and in which there are low levels of offending. All of that adds up to the definition of wellbeing, and I would be content to go with that as a purpose. The statement in the report that that should be the overarching aim that all the targets should lead towards is the first time that I have ever seen that.

Ivan McKee: At least three frameworks have been mentioned—there is the national performance framework, the local delivery plans and health and social care. Is there a need to get them into one? If so, whose job is it to do that?

Professor Burns: We should see how it all interacts. The health service targets are one sliver of a broad system that, if managed appropriately, could enhance wellbeing and lead to decreased demand and better outcomes in the national performance framework.

Ivan McKee: So those should all be crunched into one.

Professor Burns: They should be seen as part of one system. To be perfectly honest, I do not know what the mechanism is for changing the national performance framework. Again, we have focused on health and on the idea that what can be measured is what counts. In the national performance framework, outcomes are measured every year or every three years.

12:00

Alison Johnstone: It is clear that you are advocating a greater focus on the early years, as you did in your previous role as chief medical officer. The new CMO has a different focus. We have been speaking a lot about care for the elderly, chronic illnesses and the realistic medicine agenda, whereas you are advocating a life-course approach. How might that help us address some of the challenges that we face? You note that Scotland has the lowest life expectancy of 16 western European countries and that that has only become the case since the 1960s. What might that life-course approach look like and how could it help us address some of the unintended consequences of the targets?

Professor Burns: The evidence around adverse childhood experiences comes predominantly from a very large, prolonged American study, a study carried out in New Zealand, some work done in England and so on. For children who experience four or more very clearly defined adverse events, such as physical violence, emotional neglect, or parental absence, either through parental imprisonment or parental mental health problems—postnatal depression, for

example, is a very significant adverse childhood experience—the evidence shows that when they grow up, they are eight times more likely to become alcoholics or other substance misusers, eight times more likely to be arrested for violence, significantly more likely never to work, significantly more likely to require healthcare and so on.

The English study showed that if someone had none of the nine defined adverse events in early life, they had a 35 per cent chance of having a chronic illness by age 60; if they had four or more, it was a 70 per cent chance. The American study has calculated that one year's worth of child neglect in the US brings with it a lifetime cost to the American economy of $124 billion in terms of demand for support and care, failure to pay taxes, because those individuals never work, and so on. Pro rata, the Scottish equivalent is that one year's worth of child neglect in Scotland may bring with it a lifetime cost of £1.8 billion. If we get early years right, children do better at school, they are less likely to fail when they move into the workplace and they are less likely to go to jail. Their life course begins to move in a different direction.

A report that was published a few weeks ago pointed out that the greatest number of deaths from drug and alcohol abuse in Scotland were in 40-year-olds. Ten or 15 years ago, the highest number of deaths from drug and alcohol abuse was in 20-year-olds. What we are seeing is a cohort effect. People born in the 1960s or around that era are moving through the life course and acquiring all sorts of problems. The way to begin to fix it is to change the life course at the beginning. Yes, we have to do things for the others—we have to support them and provide services for them—but we had better start getting it right in the early years if we want to have a flourishing population.

Alison Johnstone: If we know that those mortality effects relate greatly to young people or that those young people are now carrying conditions throughout life, what can we do to make sure that we address that? All the targets that we have been discussing seem far removed from that life-course approach.

Professor Burns: The work that I have done over the past 10 or 15 years has been to demonstrate the biological consequences of adversity in early life. It always seemed to me that if one just expressed an opinion that adversity in early life led to all sorts of problems later on, folk might recognise that, but if one could show that there are biological changes that lead to problems, nobody would be able to argue with that. We have shown that through studies carried out in Glasgow that involved measuring neurological function and so on. Fundamentally, in children who experience adversity in early life, brain development leads to reduced ability to learn, reduced ability to suppress inappropriate behaviour and increased emotional lability. We have kids at school who are more anxious, aggressive and fearful, less able to suppress those tendencies and less able to learn. We have shown biologically different brain patterns in affluent and deprived Scots. We have measured psychological function and so on.

Can we change that in later life? This is relatively new science, but the evidence is emerging that certain things can be done to reverse some of those brain changes. One of the most important—you see this in the third sector, which is particularly successful at it—is mentoring and supporting individuals who are living chaotic lives.

I will give you an example of a jaw-dropping outcome. I recently gave a lecture to English chief constables at one of their continuing professional development days. Afterwards, a chief constable of a county in England said to me that his force was doing a randomised controlled trial of criminal justice. People who were arrested in his county went through a screening programme. For serious offenders such as murderers, there was no question about it: they were charged and they went through court. However, medium and low-risk offenders were randomly allocated to being charged and going to court or to not being charged and therefore not acquiring a criminal record, and having a support package of mentoring and so on. He said that the follow-up after two years showed that the re-offending rate of those who went to court was 65 per cent—for those who got the support package it was less than 10 per cent.

There are all sorts of different ways of doing this. If we follow those folk through the life course and support them in ways that keep them involved and engaged in society, we will begin to deal with that bulge of low life expectancy.

Alison Johnstone: We recently heard from ex-prisoners in an informal session. One of them, who had been in prison several times—the convener will know who I am talking about—said that those in prison had changed markedly over the years. He said that prison felt more like a mental health ward now. One of your suggestions is reporting the incidence of prevalence of mental health problems by the Scottish index of multiple deprivation. Why would that be useful when it comes to identifying the impact of other interventions?

Professor Burns: We can look at things such as domestic violence. Given all the focus that is on education just now, it is interesting that the American study shows that the biggest predictor of educational failure is witnessing domestic violence in the home. Adverse childhood events are not exclusively associated with low socioeconomic

status, but they tend to be more common in areas of low socioeconomic status. That is largely because of worries about money and worries about alcohol consumption.

There is a cyclical effect, which I have referred to as the cycle of alienation. I talk to young people in prison. If, for example, I ask an 18-year-old in Polmont who is about to get out what he is going to do when he gets out, he might say, "I will never get a job. I have got a criminal record." If I ask, "So what are you going to do?", he will say, "I will sit at home, watch telly and drink." That is literally what I have been told, but what such people do not factor into the equation is that their girlfriend will have a baby and that baby will then be born into a chaotic household. That is where you begin to break that intergenerational cycle. It is hugely important for us to focus on that life course, and to note that the focus begins with adversity in families. If we focus on them we will see that bulge of dysfunctionality moving out of the system.

Alex Cole-Hamilton: Good morning, professor. Your section on adverse childhood experiences was music to my ears, as I worked in the voluntary sector for 15 years, eight years of which was for an organisation that delivered trauma recovery for children of all ages. I was delighted to see that and delighted to see your push towards a more trauma-informed approach. The National Society for the Prevention of Cruelty to Children report "The right to recover: therapeutic services for children and young people following sexual abuse" identified that 15 out of 17 local authorities that they examined did not have any trauma recovery services for the under-fives and a further 11 of those 17 had nothing for primary school-aged children either. In your recommendations, you suggest that we should set up a protocol for the management of such cases. That is as close as you come to calling for the widespread introduction of trauma recovery services. Why did you pull your punches on that?

Professor Burns: Because that was not what I was asked to do. I would anticipate—and I earnestly hope—that some group is set up to consider the collection of data on adverse experiences and the management of it. If we start off by identifying the problem, I would love to be involved in further discussions on it.

I have been looking at this issue. One of the most interesting things in this area is the Barnahus system in Scandinavia. The problem is that for a three-year-old who has experienced abuse—either sexual abuse, which can happen in nursery schools, or physical abuse—the current system reinforces the trauma, as a result of legal requirements. The accused has the right to be there. The child could be having their evidence filmed, but video has often been an instrument of the abuse. The trauma is reinforced by the way that we manage it, so we have to start looking at alternatives. The Scandinavian system, as is often the case, has a far more sensitive and rational way of collecting evidence that allows abusers to be dealt with.

However, it was not my job to look at that. I was not asked to come up with the solutions; I was there to say, "Our targets and indicators system is probably not fit for purpose."

Alex Cole-Hamilton: I get that. I understand that it would have felt like mission creep to start laying out recommendations that might have been more linked to your work with the early years collaborative. I support what you have just said, though, because I absolutely believe that we still have a cultural reality in which what gets measured gets done. If we measure childhood trauma and lack of trauma recovery, perhaps that will pump-prime local authorities, health boards and everything else to build those services around the children.

Jenny Gilruth: I would like to take you back to the national performance framework, which looks at dental health, child and adolescent mental health services, waiting times and babies of healthy body weight. In the report, you go on to mention the getting it right for every child approach. You say:

> "It is not clear how this system identifies ACEs and it would be helpful to see if there is a standard approach to identifying and managing neglect in babies."

When it comes to those processes and outcomes, do you think that there is a disconnect between education and health?

Professor Burns: No. I probably talk to more teachers than doctors.

Jenny Gilruth: I know—in fact, the last time I saw you, you were in front of my higher class.

Professor Burns: I get more sense out of teachers than I get out of doctors. [*Laughter*.]

There is an understanding of the close link, but there is no real understanding of how to manage it. I recently spoke to a headteacher who had just been given £500,000 for his school to spend on whatever he liked. His comment to me was, "I don't really need this—I'd far rather it was spent on giving the kids a decent breakfast before they came to school." That is part of it.

12:15

People have different ideas. We are a small enough country for people to be able to get together and say, "What is the link here?" The link is absolutely cast-iron: adversity before someone goes to school leads to failure when they get to

school. If we are serious about having a flourishing, inclusive economy, we have to get that link built more strongly. Well-meaning policies such as GIRFEC have arrived, but it is time someone came up with a system to create success at school and pulled all of that together.

Jenny Gilruth: I agree.

In paragraph 72(a), on page 18 of the report, you recommend:

"Analysis of school attainment rates should routinely consider the effect of adverse circumstances arising from socioeconomic deprivation on attainment."

School attainment data is a very narrow measure. What other factors do you think should be taken into consideration?

Professor Burns: What are the things that influence the attainment rate? We have already mentioned factors such as adversity and exposure to violence. One of the most complex issues here is the notion of mentoring. All of us have someone in their family who was the first to go to university. We probably all started off coming from a poor background. I keep coming across stories of mentoring. For example, I bumped into a former medical colleague who was volunteering as a mentor, and the boy he was mentoring, who lived in Possilpark, had just got a place in medical school. The boy was so poor that he had to walk the 45 minutes to school and back every day because he could not afford the bus fare. There are guys from Lenzie and Bearsden who come from the best schools in Scotland who do not get into medical school. We need to have more of a focus on supporting people who might not feel that they have any place at university and convincing them that they do.

There are a number of projects out there on developing the young workforce. There is a programme in Newlands in Glasgow that takes troubled children and trains them very effectively to go to university or to succeed in some other way. There are ways of achieving success that we should collect data on. We should try to have a more consistent approach, because if we have a piecemeal approach, everything just gets fragmented.

Brian Whittle: Good afternoon. This is a fascinating topic, especially the link between education and health. With that link and early intervention in mind, why are we not linking health targets with educational targets? Should we be taking a more cross-portfolio approach?

I am really interested in understanding the idea of lack of access to opportunity at a very early age. With the 30 hours of free childcare, do we have an opportunity to make a more positive intervention? If some kids are likely to be 40 per cent behind by the time they get to primary school, why are we focusing on primary school?

Professor Burns: That comes back to the idea of the life-course approach. Basically, the life course begins as soon as the pregnancy test is positive. When the United Kingdom chief medical officers considered recommendations on alcohol consumption during pregnancy a few years ago, I was the only one who said, "I want the recommendation to be that no alcohol should be consumed during pregnancy." The others said, "One or two drinks might be all right." Drinking alcohol during pregnancy has an impact on brain development.

That is the starting point. We need to look at the whole life course in that way. We should not start at the age of five. In fact, the adverse childhood events study calculated cognitive performance at age two and age 10 by socioeconomic status. At the age of two, there was a group on the 90th centile—very high performers—from affluent and deprived backgrounds. By the age of 10, the affluent children had maintained their cognitive functioning, whereas the deprived ones had deteriorated. The evidence is that there are things that we need to do to support those kids throughout their childhood to enable them to achieve the best possible educational outcome.

You are absolutely right when you talk about the need for a holistic approach to pull everything together. At the moment, we have different groups working in different silos to do similar things. Ultimately, we are not going to get a harmonious result or one that we can apply indicators to effectively.

I want us to co-produce—with teachers, children's carers, third sector organisations and so on—a programme for leading children to the best possible intellectual place over the first 10 years of life, because if we get them to that point, they will do quite well thereafter. At the moment, we do not have any way of doing that, which is why I said that we should have a set of indicators for that, but it is not up to me to say what they should be—it is up to the whole system to design them.

Brian Whittle: If we extrapolate from that, could we realistically state that educational intervention has such a huge impact on health outcomes later in life that we should be focusing on education much more?

Professor Burns: I spent five years as a consultant surgeon at Glasgow royal infirmary, and it was that experience that prompted me to go into public health, because I kept having patients come to me—as a surgeon—who were there to see me because they drank too much and had a gastrointestinal haemorrhage or something like that. I would say to them, "If you don't stop

drinking, you're going to die," and the response would be something along the lines of, "Why should I care? Life's really crap, and I don't care. The drink's the only thing that makes life worth while." People get to that point in life at which they have no sense of purpose, no sense of meaning and no sense of self-efficacy in life, and that comes about largely because they have had a difficult childhood that has sent them on that road to a cycle of alienation.

A kid who experiences adverse events is more emotionally labile or less able to suppress his feelings. He is badly behaved, so he gets excluded from school because he is disrupting education. I think that that policy is nuts. When I asked an education department whether it could provide me with data on who was excluded from school, it could not. It did not know who was being excluded or how often they were being excluded.

Because such kids are excluded from school, they get it into their heads that they are stupid, they end up drinking bottles of cheap vodka—maybe it will no longer be so cheap—they get into fights and they go to jail. That is often the life course that adversity sets them on, unless they get picked up very early on and get mentored and supported. It is not in my nature to talk about the issue in purely economic terms, but that is a huge waste of human capital. Those are the kids who should be the doctors and the lawyers—no; I will leave the lawyers out of it. [*Laughter*.] They should be the doctors, the engineers, the inventors, the artists and the musicians; instead, they are ending up in Polmont.

Brian Whittle: I could talk about this all day, but I will give somebody else—

Professor Burns: I am happy to talk about it all day.

The Convener: I want to pick up on a couple of the issues that you have raised. In a number of those areas, whether in early life or elsewhere, the people who would have picked up on what was happening would have been youth workers, child development workers and third sector organisations that were employed or funded by local government. How can we address the very serious issues that you raise when local government services are disappearing through our fingers? I know from your previous work that you worked closely with local government, so you will know this stuff inside out. Given what is going on at the moment, are we not in danger of exacerbating the problem?

Professor Burns: I am in the process of working with five or six local authorities and their associated health boards. We are thinking about applying a different pattern of service to people who live in difficult circumstances and measuring it. I am in the process of pulling that work together. Just yesterday, I interviewed for four PhD students who would help me to assess the impact of such an approach. There is no doubt that we need to work differently with the public sector and third sector organisations that confront this kind of problem. My hope is that that will give us the evidence that we need.

I think that youth workers might be intervening too late; I think that the work needs to start—

The Convener: It is child development workers, nursery staff and outreach workers that we need.

Professor Burns: Yes—we need nursery staff and health visitors. We need things such as the family nurse partnership. One of the most inspiring things that I have ever witnessed was the result of work that family nurses had done with six pregnant 16-year-olds. I met one of those young girls and watched her with her baby. The attachment between her and the baby was absolutely secure. The father appeared, and he was similarly attached. The girl then said, "Right, I have to go now—there's a taxi waiting to take me back to school." She was sitting five highers and she wanted to be a lawyer. I said to the family nurse, "If you hadn't been there, what would she be doing now?" She said, "She'd be wheeling the pram down to the shopping centre and drinking with her mates." That kind of intervention is expensive, but it is gold dust. As I said earlier, one year's worth of child neglect could have a lifetime cost of £1.8 billion.

The Convener: But such services do not run on fresh air.

Professor Burns: They do not.

Ash Denham: It has been a very interesting discussion, but I am going to change the topic slightly and go back to the targets. You recommended keeping most of the targets, but one that you suggested should perhaps be dropped is the 18-week guarantee, because that possibly alters clinical decision making. Can you say a bit more about that?

Professor Burns: Yes. Let us say that someone presents with a complex problem such as complex abdominal pain. They may have an orthopaedic issue or whatever. For a start, it can take a good few weeks to run down the diagnosis, and it might be that, as the diagnosis is being narrowed down with different tests and so on, different options for treatment appear. The patient may be offered a treatment and they may ask to go away and think about it. If the clock is ticking, that puts pressure on both the clinician, who is trying to come up with the right management strategy, and the patient, who may want to take time to think about it. You could come up with all sorts of strategies such as the clock stopping

whenever the patient decides they want to think about the proposed treatment and so on, but that would not build good clinician-patient relationships. You want to build a relationship in which the clinician is trusted and feels that he is supporting the patient.

I would not want to go back to the days when, as a consultant surgeon, I used to manage my own waiting list. Like all the other surgeons in the Glasgow royal infirmary, I had a waiting list and, every week, I would take patients off it for the next week's surgery. The more serious cases came off and the ones waiting for varicose veins surgery, hernia repair or whatever might wait for two years. All of that was swept away because of a big investment in waiting list initiatives. I never practised privately, but my colleagues who did were driving big, flashy cars on the back of the waiting list initiatives. They made a lot of money out of them.

Patients should not have to wait, but imposing a target that might interfere with the clinical decision making and the doctor-patient relationship is not a good thing to do, especially when the target is not legally enforceable.

12:30

Ash Denham: You said that it might affect patient choice as well. Patients need time and decision support tools to make an informed choice about their treatment.

Professor Burns: Yes.

Ash Denham: If the 18-week guarantee is cutting across such issues, how can we decide on a better target that would lead to the outcomes that we are looking for?

Professor Burns: Once the decision is made, there is the 10-week target, which is there as a backstop. I am talking about the process between referral and deciding what is clinically indicated and what the patient wants to accept, which can take longer than eight weeks even with all things working smoothly.

Complex problems should not be rushed at. The clinician needs to stop, think and discuss with the patient what the options might be. I am seeking decision support tools. Things such as the internet are making patients much more aware of their options, which is a good thing. In the old days, I would see a patient and say that they needed such-and-such an operation, and they would say, "Aye, okay," and go away. Things have improved a lot. The word "empowered" is overused, but patients should feel more in control of the big decisions.

Miles Briggs: I want to look at what impact our target-based approach to health is having on the work that is done in our health services. This week, it has been reported that, across NHS Lothian's accident and emergency units, there has been underreporting of waiting times. Is the massaging of figures or underreporting becoming common throughout the health service?

Professor Burns: I have no factual insights into that, so anything that I say should not be taken as gospel. It would not surprise me, however, because what gets measured is what counts. People who work in the health service genuinely want to do a good job for their patients, and putting them in a position where they might have to be dishonest is not a good thing.

That is why I am suggesting that you look at the whole system. If a lot of people are waiting in an A and E department, is that because there are not sufficient beds? Is it because there are too many inappropriate folk pitching up who have problems that could be more effectively managed elsewhere? We need to understand the situation and not put the blame on hard-pressed A and E staff. That is why I am suggesting co-production. Involve people in designing what the processes and indicators should be, and you will find that they go much further than what a bunch of officials would do, because they want to do the right thing.

I am absolutely stunned by the results of the patient safety programme, whereby the front-line staff got the bit between their teeth and eradicated whole swaths of infections. When I worked in intensive care units, 90 per cent of people who had been ventilated for more than a week had ventilator-acquired pneumonia. Nowadays, in some hospitals, it is years since they have seen ventilator-acquired pneumonia, because the staff changed the way that they worked. Involve them and you will get outcomes far better than you ever anticipated.

Miles Briggs: How can we move to that outcomes-focused NHS? There are lots of pilots—we hear about them all the time. There is lots of good work in certain areas, but that does not get rolled out and there does not seem to be any learning from it. You talk about systems thinking, but how can we make sure that professionals take professional responsibility, and how would you go about measuring that?

Professor Burns: When we ran the early years collaborative, every five or six months we would get 800 people from every local authority and every health board in Scotland who were involved in early years care into a room, where they would sit down and share ideas. It is like athletics without the drugs.

Brian Whittle: You have got my attention now.

Professor Burns: Perhaps it would be more appropriate to talk about the UK cycling team.

Brian Whittle: That is better.

The Convener: You are losing both the athletes and the cyclists.

Professor Burns: There have been lots of marginal gains. We tested things and got a 2 or 3 per cent improvement in performance. We counted 1,500 things that were tried by the earliest collaboratives, and maybe 60 of them actually produced a benefit. Where all 60 of them were done consistently and the data was collected, there was a step up in performance. An 18 per cent reduction in the stillbirth rate over a matter of a few years is unheard of.

It is about bringing people together and making it plain that we want to hear what they are doing. We want to hear what works and, crucially, we want to hear what they have tried that does not work. There is no shame in failure except in not telling people that you have failed. It is about saying, "We tried this and it didn't work, so don't waste your time," and gradually building improvement in that way. A colleague up in St Andrew's house, Professor Jason Leitch, is a guy who can do that. He certainly frightens me.

Emma Harper: We have covered a lot of what I was thinking about. Last week, Dr Mackintosh talked about the original paternalism of healthcare and the idea that, if you can count it, it counts. You have talked about that as well. He said that a more professional or moral approach is what we need, not forgetting that targets inform us about where we need to go.

I was directly involved in the Scottish patient safety programme as a clinical educator nurse at NHS Dumfries and Galloway, and we took a multidisciplinary team approach because that is how we got all the views. I am interested to hear your thoughts about whether we should move to a less target-driven culture and take a more professional or moral approach, as Dr Mackintosh outlined.

Professor Burns: We need a less target-driven approach but a stronger indicator-driven approach. Targets delineate the end of a journey—"Okay, we have made the target. We can stop trying,"—but indicators tell us our direction of travel. A 15 per cent reduction in infant mortality is a good thing, but we should keep going, and indicators are about understanding the way in which we want to go. In the earliest collaboratives, ensuring that 90 per cent of children attained all their developmental milestones at the 30 months health visitor assessment was something that the front-line staff identified as an indicator on the way to improving intellectual performance.

We need indicators, but indicators need to be feasible. They need to be pragmatic, they need to be co-produced and we need to be able to say, "Okay, we've done that now. What's the next thing?" At the moment, some targets seem to be cast in stone and there is no thought that we would move away from them. We should be aiming high, and indicators tell us that we are shooting for the stars, although we do not want a target that prevents people from trying. In bringing people together, it is critical to have not only those on the front line but the bosses there. The heads of health boards must show those on the front line by their presence that the meetings are important.

When Gerry Marr was the chief executive of NHS Tayside, the front-line staff were really impressed that he came on ward rounds. The chief executive of the health board was there on ward rounds to show that hand washing and so on was important. He was taking an interest in what they were doing. Having leadership from the top while having front-line staff there to create the change is the way to do it.

Emma Harper: With the co-production that you are talking about and all these masses of programmes and integration joint boards, there is so much happening. Will we see a tipping point eventually? Those at the front line have to engage in constant hard work, as does everyone else, but surely there must be light at the end of the tunnel.

Professor Burns: The integration of health and social care is really important. We have talked about integration with education and that kind of stuff, which is important, but we are creating new organisations. Organisations tend to have their boundaries and cross-boundary working, and the more you fragment the system, the less able you are to get a coherent strategy. That is why the report starts by talking about how we will achieve a flourishing population in Scotland. Let us start from there and see how we design a system that takes us all there.

I have never been a member of any political party, nor would I ever want to be. There are things in this that go right across the political spectrum—social justice, excellence in outcomes, economic development and so on. It is about creating a society that we all feel proud of. If we put that ideal at the forefront, how do we design the indicators to show how we get there? If you want me to go back and do phase 2 of this, I could design something, but the system must be co-designed by the people who have to deliver it.

The Convener: What is the next stage of the process?

Professor Burns: You would have to ask colleagues up the hill.

The Convener: Who are those folk up the hill? Tell us who they are. I have never met them.

Professor Burns: I was asked to do this by Mr John Connaghan, who was the director of performance and is now no longer up the hill. He is now the chief operating officer of the health service in Ireland.

The Convener: Is that because his performance was good or because it was not so good?

Professor Burns: I think you would regard it as good, because he is still going to be in the European Union—but let us not go there.

My fear is that the system will get taken away and, in the traditional way, designed by civil servants, whereas it needs to be designed by the people who are actually working within it. A year has gone by and I am just getting out there and doing it. I got money from various sources. An American charity heard about what I am doing and said that it would like to support the work because it wanted to do the same in the US. It told me to ask it for some money, so I asked it for £500,000 and it got back to me and said that I had not asked it for nearly enough.

A group of local authorities are expressing an interest and are trying to integrate things differently.

The Convener: Is that work being done by you on your own?

Professor Burns: Yes.

The Convener: The committee needs to know what the next stage in the process is.

Professor Burns: It would be very helpful for me to know that, too.

The Convener: That is probably a good place to finish. Thank you very much. As always, it has been good to have you before the committee. It always provokes an interesting conversation and there is much for us to think about.

Professor Burns: Thanks a lot.

12:43

Meeting continued in private until 12:52.

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

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