OFFICIAL REPORT
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Health and Sport Committee

Tuesday 30 October 2018

Session 5

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HEALTH AND SPORT COMMITTEE
27th Meeting 2018, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*Miles Briggs (Lothian) (Con)
*Keith Brown (Clackmannanshire and Dunblane) (SNP)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jeff Ace (NHS Dumfries and Galloway)
Dr Kenneth Donaldson (NHS Dumfries and Galloway)
Bob Doris (Glasgow Maryhill and Springburn) (SNP)
Philip Jones (NHS Dumfries and Galloway)
Julie White (NHS Dumfries and Galloway)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 30 October 2018

[The Convener opened the meeting at 10:00]

Scrutiny of NHS Boards (NHS Dumfries and Galloway)

The Convener (Lewis Macdonald): Good morning and welcome to the 27th meeting in 2018 of the Health and Sport Committee. I ask everyone in the room to ensure that mobiles are switched to silent. We have received apologies from David Torrance, and Bob Doris is substituting for him.

The first item on our agenda is an evidence session with NHS Dumfries and Galloway, as part of our programme of one-off evidence sessions with each of the territorial health boards. The focus of these sessions is on performance against local delivery plans.

I welcome to the committee the chairman of NHS Dumfries and Galloway, Philip Jones; Jeff Ace, the chief executive; Julie White, the chief operating officer and chief officer of the integration joint board; and Dr Kenneth Donaldson, the medical director.

I will begin by asking about issues of financial sustainability. There will be a statement in Parliament this afternoon on last week's report by Audit Scotland. I am sure that all health boards will have read that report avidly over the last few days. Clearly, each board has its own challenges to face and issues to address. What progress is the board making to ensure that savings are achieved on a recurring and sustainable basis?

Philip Jones (NHS Dumfries and Galloway): Thank you for the invitation. I am pleased to answer all your questions, which we will take either in turn or collectively.

Jeff Ace (NHS Dumfries and Galloway): I thought that the Audit Scotland report was very fair in its assessment of the challenges. We have been a board that has always broken even. It has been tough over the past five or six years in particular, but we have always achieved our revenue and capital targets. This year is by far and away the toughest that it has ever been. We still believe that we will achieve a break-even position at the year end. However, as you will see from some of our submissions, we are using a significant amount of non-recurrent windfall savings to achieve that position. The challenge for us, exactly as set out in the Audit Scotland report, is to create that three to five-year vision of what a sustainable health and social care system looks like with the resources that we have to play with.

From a parochial point of view, the biggest single cost improvement that we can make in Dumfries and Galloway is through addressing our recruitment challenges. We are paying a considerable premium at the moment for locum staff—locum medical staff in particular—and agency costs have been creeping up. If we can address those recruitment challenges, that will make a significant financial contribution in the range of £5 million to £7 million of potential savings. Hopefully you will hear from Ken Donaldson and others about some of the work that we are doing to address those challenges.

As you will have heard from colleagues across Scotland, we are in a difficult position. We believe that we will break even this year but the prize is for us to set out a sustainable model for you. At the moment we do not have that model for the next three to five years.

The Convener: One of the striking things in the Audit Scotland report is the extent to which health boards across the country have been uncertain about where they will find the savings for a given financial year and how that uncertainty has increased from the beginning of the financial year two years ago, through the beginning of the most recent financial year to the beginning of this one. Is that also the case for you? You talk about finding £6 million or £7 million of potential savings. Does that include a significant number of savings that you have not yet been able to identify?

Jeff Ace: We have unidentified savings at the moment, which we will need to pull back by the year end just to break even. The figure changes weekly, as you can imagine in an organisation with a turnover of £350 million to £360 million. At the moment, we are looking at an unidentified savings gap of around £3 million. That is within the range that it is achievable for us to pull back. Much more concerning is that, if I look at our underlying financial position and strip out all those non-recurrent savings, I am looking at a gap of closer to £9 million to £11 million as my challenge for next year. That is a big target after five or six years of making difficult cost savings.

At this point, it might be useful to hear from Julie White, as the board chief operating officer and the chief officer of the integration joint board, about some of the on-going plans and the potential plans for next year.

Julie White (NHS Dumfries and Galloway): On our long-term plans, the health and social care partnership has introduced a three to five-year business transformation programme for reducing expenditure on health and social care services and producing the required level of savings. It is

about addressing the challenges that were highlighted in the Audit Scotland report around transforming the way in which we deliver health and social care services.

Our business transformation programme contains a number of specific projects that are looking at the redesign of health and social care services within our localities, and at the future shape of how we deliver social care services, with more focus on prevention. We are also looking at specific savings in our social work budgets within the health and social care partnership. In addition, we have given each of our directorates a 2 per cent efficiency target and we expect each of our service areas to deliver on that within the next year. Plans are being developed in partnership with our clinical and professional teams to deliver those targets.

As Jeff Ace said, however, we have significant challenges in recruitment in Dumfries and Galloway and not just within health—those challenges exist across health and social care. Our provider partners within the local authority, such as our care-at-home providers and our care home providers, are also struggling to recruit staff. Recruitment remains a significant challenge across the health and social care partnership.

Jeff Ace: From my perspective as the board chief executive, if we are faced with a 1 to 1.5 per cent cost reduction target, I can be fairly relaxed. Our systems tend to innovate at about that rate and will generate their own cost efficiencies of around 1 to 1.5 per cent. The difficulty over the past two or three years is that the target has been 2.5 per cent plus. That is where we have had to rely on non-recurrent savings. We are doing a lot of property rationalisation and we have been able to take advantage of our move to the new hospital to divest ourselves of some very expensive older facilities. However, that type of action can be taken only once and our concern at the moment is about future viability. Cost reduction targets of around 2 to 2.5 per cent are more than health systems have historically generated in savings.

Sandra White (Glasgow Kelvin) (SNP): Having read the Audit Scotland report, I am interested in the issue of rising drugs costs. That is also mentioned as a challenge in your written submission. I know that NHS Dumfries and Galloway made some efficiency savings in that area in 2017-18, when approximately 9 per cent of expenditure related to drugs compared with 13 per cent in 2016-17. What steps is the board taking to help reduce that expenditure?

Jeff Ace: I will bring in Kenneth Donaldson to answer specifically on some areas of realistic medicine that we are addressing. However, as a general point on drugs, the increase in acute drug costs over the past five or six years has been a real problem for us. The Scottish Government has been aware of that and has been very helpful in establishing the new drugs fund, which has enabled us to deal with some of those problems up until now.

However, if the pace of increase in acute drugs—particularly high-cost, end-of-life drugs—continues and we do not see industry adapting its pricing model in line with our financial pressures, it is difficult to see how we can continually generate enough money to meet the inflation in drugs costs.

Previously, we were worried about the growth in general practitioner prescribing, but acute prescribing over the past four to six years has been beyond our predictions. That has been a real change.

Dr Kenneth Donaldson (NHS Dumfries and Galloway): As members know, there is a national agenda around realistic medicine and it is one way in which we can look at reducing spending on drugs, especially high-cost drugs. Those drugs are available and they can often be fantastic and life enhancing; however, as Jeff Ace mentioned, they can also often be used at the end of life, where they are maybe not actually adding quality.

A key part of changing that will be cultural change—in the medical community as well as in the general public—around asking questions about the quality that we are getting from the medication and whether it will extend our lives or give us enough time that is of value. The part of the realistic medicine agenda around shared decision making is striving to address that by having real and meaningful conversations with patients and their families around all available forms of treatment, including drugs.

In Dumfries and Galloway, we have been working on realistic medicine for several years. We have a dedicated team, which is led by one of our associate medical directors, as well as a number of areas of improvement that are looking at shared decision making and getting quality feedback from patients about how they feel that consultations have gone. That leads to smaller pieces of work to change behaviours in the medical community and on public expectations of that change.

There are also a number of areas of work at the lower end, where medication is not quite so expensive but is nonetheless perhaps unnecessary. We must ensure that, if we are using medication, we are using the options that are most cost effective and add the best value. That is also about public engagement and education around what the public should be asking for and what we should be delivering.

Sandra White: The situation is obviously not an issue just in Dumfries and Galloway—it is a

national issue. Is managing public expectations one of the biggest problems? On a national level, could it also be the case that people's expectations are influenced by newspapers, which will sometimes create a story out of whether particular drugs are available?

Mr Ace mentioned the rising cost of drugs. Should we perhaps be doing something about the profit that the drug companies are making? You perhaps do not want to answer that question, but you stated that costs have risen over the past five years. It seems that the drug companies have an unfair advantage, particularly when that is mixed with the influence that the media can have on the expectations of the general public in how they tell the story. How do we tackle that?

Jeff Ace: That is a profoundly difficult question and clearly not just a Scottish question. What products the drug companies choose to produce and at what price is an issue that affects the whole of western medicine and is very challenging.

The Scottish Medicines Consortium, which was established around 2000 or 2001, was ground breaking in its time and created a challenge back to industry about the value that we would put on new products. We used quite sophisticated health economic evaluations to look at quality-adjusted life years and the price that we would pay for a new product. That created a different relationship with industry.

I understand that, relatively recently, we have made exceptions to that process for end-of-life drugs for some cancer products. I fully understand why, ethically and morally, that is seen as the right way to go. However, we must make sure that we do not lose that challenge back to industry, which enables us to procure at a price that does not cause huge pressure elsewhere in the system. Clearly, it is very easy for us as health systems to spend money, but it is enormously difficult to fund that increase by taking money from elsewhere.

Sandra White: Do we have evidence from other countries of the drugs that are being put forward just now being cheaper to buy?

Jeff Ace: It has been a while since I sat on the Scottish Medicines Consortium, so I might be slightly out of date. There are different approaches across the world. New Zealand used to be cited as a country that had a negligible relationship with industry and bought at spot price, constantly seeking the lowest market price. The difficulty with that example is that New Zealand has no pharmaceutical industry, so patients there do not benefit from research projects or rapid access to drug trials in the same way that patients in Scotland do. There needs to be a partnership with industry—that is valuable to the citizens of Scotland—but it must not come at the cost of us not being able to challenge back effectively on product price.

10:15

Sandra White: Do you think that Brexit will make it more difficult to get the drugs at a reasonable price? Might the price be higher or might we be unable to get them at all?

Dr Donaldson: That is possible. From a health service point of view, there are two distinct Brexit issues. There is the short-term disruption of a no deal, in which case we would be very concerned about the availability of a number of products. In the longer term, because we are potentially moving out of the European Medicines Agency, there may be some requirement to purchase from global markets. That will almost inevitably be more expensive and we can see examples of products that are more expensive by a factor of three or four times than those that we are currently procuring. I do not wish to be flippant, but it is hard to find an area in which Brexit does not give us great cause for concern at the moment. Drugs is certainly one of those.

Bob Doris (Glasgow Maryhill and Springburn) (SNP): I am conscious that the pricing of medicines is a reserved issue and done on a pan-United Kingdom basis, but reimbursement is devolved to the SMC. There are special measures being developed that are on-going and active. The committee will be looking at those in relation to orphan and ultra-orphan medicines for rare conditions. There is a lot of emerging good partnership work on outcomes-based reimbursement for orphan and ultra-orphan medicines. Drug companies make huge claims—shock horror—about the benefits of certain medicines and procedures but they do not actually know, in real time, how they will deliver until that medication is actually being administered.

Scotland is great at retaining data and following patients, through the community health index number, all the way through their progress. There is a real opportunity to make drugs affordable because, if drug companies do as they say they will, there is delivery and boards can save money. Is NHS Dumfries and Galloway actively involved in discussions with the SMC and the Scottish Government to look at outcomes-based reimbursement, not only for orphan and ultra-orphan conditions, but more widely?

Dr Donaldson: We are represented around the SMC table and the new drugs committee table. We are in the midst of that. As you say, it is a fascinating area. There has been some concern, for a considerable number of years, about the fullness of the clinical trial data that is presented publicly and about which trials are published and

which are not. The outcomes-based approach that you are suggesting gets around that completely and gives us genuine real patient data, which will be invaluable.

David Stewart (Highlands and Islands) (Lab): Going back to Brexit, I have taken a big interest over the past six months in the withdrawal from the European Atomic Energy Community, or Euratom, which was notified in the article 50 letter by the Prime Minister. The great concern that I have is that we import our radio isotopes from Europe, which provides 60 to 80 per cent of the world's source. You will know, as medical experts, the great worries about half lives and the fact that the isotopes cannot be stored very easily. Has the board specifically looked at that?

Dr Donaldson: The board will take a paper to the public board in either its December 2018 or January 2019 performance committee on the risks of Brexit to NHS Dumfries and Galloway. We are sharing that paper with other mainland boards to make sure that we have a co-ordinated risk assessment and the same understanding of where the risks lie. As with all territorial boards, there is a real concern over a no-deal scenario and the instruction that we have had to plan for potentially six to 12 weeks of disruption to our supply chains. That affects the Euratom products, our basic clinical products and, indeed, how we feed and maintain patients in hospitals. Therefore, we are profoundly concerned about the prospect of a no deal. I hesitate to comment on any prospective deal until I can see the information on it.

Emma Harper (South Scotland) (SNP): I declare an interest as a former employee of NHS Dumfries and Galloway. I know everyone around the table this morning. Thanks for coming.

I am interested in hearing about the new Dumfries and Galloway royal infirmary, the planning, the process and the settling in. It has been almost a year now. There are obviously challenges with running concurrent sites at Mountainhall and the new build, but a brand new hospital for Dumfries and Galloway is a good news story that we should be sharing. However, I would like to hear about the obvious financial challenges and pressures associated with the move to the new hospital.

Philip Jones: The new hospital was eight to 10 years in the planning, development and delivery. The planning partnership with High Wood Health was a successful model for us in Dumfries and Galloway, particularly the way in which we engaged with our staffing groups in the later stages, when the hospital had been completed and was being prepared for us to take occupancy.

The human resources team did hugely significant work in facilitating familiarisation trips and meetings and discussions with small groups, so that people could understand where they were moving from and what they were moving to—people were leaving one hospital one day and starting the operation again at a new one after the weekend. A hugely successful management of change process was put in place: it was so successful that our HR team won a national HR team of the year award from the healthcare professional body for that particular piece of work.

We recognised that patient safety was most important and that to guarantee it required the staff who were moving hospital to understand where they were going and what they were doing. The new hospital has a wholly different configuration from the old one. Where, for example, people used to walk out of theatre and turn left, they do not turn left anymore. Simple issues like that were dealt with more practically as a result of the background work, which meant that people were more start ready.

I will let Jeff Ace and Julie White speak on some of the detailed aspects of the new hospital.

Jeff Ace: I will start, and then I will hand over to Julie, who was project leader throughout the new-build process and delivered what was, at the time, NHS Scotland's largest capital project, to the day on time and to the pound on budget.

We are immensely proud of what we achieved. It was far and away the biggest change project that we have ever undertaken. We had previous experience of building new facilities—in Stranraer, for example, and in Dumfries with our new mental health unit—but nothing on the scale of a complete move. Having to physically move more than 170 patients over the weekend in December, I was the most terrified that I have ever been at work, and, afterwards, the most proud that I have ever been of everyone who achieved it. It was an absolutely iconic moment for us.

I will hand over to Julie, who is the individual most responsible for its success.

The Convener: There is no pressure. [*Laughter.*]

Julie White: As Jeff Ace said, the move to the new hospital was the single largest change that any of us in the senior management team—within NHS Dumfries and Galloway and across the health and social care partnership—had been involved in. We had been planning for the move for eight years. We submitted a business case to the Scottish Government in April 2013 and successfully moved into the new hospital in December 2017. That timeframe, from submission of an outline business case to actually moving into the new hospital, has probably not been matched anywhere else in the country.

Although I appreciate Jeff Ace's kind comments, that work was undertaken very much as a team. We had an incredibly strong team working on the development of the new hospital. Much of the success was down to our clinicians, clinical teams and service teams and their engagement with us in developing the plans for the new hospital.

Emma Harper asked about some of the changes that have taken place in the new acute hospital and there has been a whole host of changes in relation to the way in which we deliver services. We have developed a combined critical care unit, which brings together what is traditionally in intensive care units with what is traditionally in surgical high-dependency and medical high-dependency units. That involved real changes to the way in which staff work and how they work together as a team. The team came together and did a lot of preparatory work before the move to the new hospital.

One of the biggest changes in the new hospital is our new emergency care centre, which houses our accident and emergency department, our GP out-of-hours service and our combined assessment unit. Our combined assessment unit is where our patients access emergency admissions for rapid assessment and diagnosis of their condition, with the expectation that as many of those patients as possible will be returned to the community.

In the first six to nine months of operation in the new hospital, our combined assessment unit sent around 41 per cent of GP admissions straight back home within about a 12-hour period, with the remaining individuals going on into downstream wards. With a combined assessment unit and emergency care centre, that level of change required a huge amount of planning and a huge investment of time from our clinical teams in looking at how we would work differently to better meet the needs of our population. That was about having an assessment unit, not an admissions unit, so that people come to the hospital for a rapid assessment and diagnosis. Wherever possible, we then support them to go back home.

The new hospital is the most digitally enabled hospital in Scotland. That was one of the key factors in developing our new hospital—there is wi-fi throughout it. The wi-fi supports the telephone system and our telemetry system, which supports the sickest patients in the hospital. We have also introduced electronic patient records, an electronic prescribing system and an electronic ordering system for diagnostic tests. We have introduced a range of technologies, including a roaming desktop in the wards, which means that clinicians can access patient information in the single-patient bedrooms. We are very proud of the technology in the new hospital.

The committee will be aware that one of the key features of the new hospital is that we moved to having 100 per cent single rooms. In the very early days of our planning, that required members of the team and me to engage with our communities, because some of our population were concerned about loneliness and isolation in single rooms. However, when we had our patient-experience week earlier in the year, we were delighted to hear that patients really loved the single-room environment, and that they felt that it made seeing their families easier. The new hospital has an open visiting policy, so family members and friends can attend the hospital at any time, day or night. Patients felt that the hospital wards were calmer as a result of the single patient bedrooms and they loved the fact that each of them had a television.

However, we got some feedback that single rooms are not ideal for some older patients, who perhaps do not have family members or friends close by. Therefore, we have done a number of things in each ward. When patients are ready, they can access a socialisation space. We have also used volunteers in the hospital. We are delighted with the number of volunteers that we have in Dumfries and Galloway. We have more than 200 volunteers and we have ward-based volunteers who support people who do not have visitors and may be isolated.

There have been lots of developments in the new hospital, and there are lots of advantages, but we have an on-going challenge around recruitment. Jeff Ace mentioned it earlier—it is one of our significant challenges.

The Convener: We will address recruitment in a moment. Will you say something about the financial pressures and the consequences of operating old and new hospitals side by side?

Jeff Ace: We had always intended to leave some ambulatory services at our old site. We have left renal dialysis, some therapies and ophthalmology at that old site to create the Mountainhall treatment centre. Those services do not need to be on acute hospital sites. We wanted to create a setting that was more suitable for ambulatory care—where people could walk up and be treated, and that has worked well. We budgeted for the double running costs of that.

What we had not sufficiently appreciated was the scale of additional staffing required in our new hospital. We had budgeted for an increase of around 80 staff, and we recruited to almost all those posts before moving, but we have since recognised that that level of staffing is not optimal and we have moved to recruit additional staff this year. That cost is within the £3 million of unidentified savings that I quoted earlier, so it is not adding any pressures. We still anticipate a

break-even position this year. However, the footprint of the hospital, the new ways of working around the frailty at the front door project and the single rooms issues are probably testing some of the traditional staffing models that we used to set our baseline staffing. Our nurse director Eddie Docherty has raised that issue nationally. We need to look at tools for single-room nursing to make sure that the advice for future developments is bang up to date.

10:30

Emma Harper: You have already covered the challenges of dual sites. How do the staff engage if, for example, you need dialysis intensive care but you are also running regular dialysis at Mountainhall? We have dialysis centres across the region in Stranraer and Kirkcudbright as well. Do the staff float? Do they agree to do that? Do the challenges include looking at models of working that the staff actually accept?

Jeff Ace: I will defer to our nephrologist beside me.

Dr Donaldson: As a renal physician, I should answer that question. There was a lot of planning around the move to split-site working. You mentioned that we have satellite units in Stranraer and Kirkcudbright. In some ways the Mountainhall centre is a satellite too, although it acts as a main base. We recognised that there would be staffing issues around this situation because we need to have rotas to allow nursing staff to be in the acute hospital to deal with the intensive care unit and renal ward, and we also need medical staff in each. Therefore, there were increases in numbers for both units. In particular, we recruited an extra consultant to have the staff numbers to make that rota workable.

As with many aspects of moving into the new hospital, there have been teething problems around how that works. However, I am pleased to say that the team are in a good place now. It is a very different way of working from the one that they are used to. When Mountainhall was the main hospital, it was very straightforward for patients to get an X-ray or to see another specialist. Now that sometimes involves having to move to the new hospital. However, we have made our processes work around that and I think that it is working really well now.

The Convener: In your submission, you refer to a £7 million banking surplus with the Scottish Government and that money being released this year and last year. How does that mechanism work? Is that a capital mechanism only, or does it also apply to revenue funding?

Jeff Ace: For a number of years, we had been brokering money with the Scottish Government in anticipation of needing it for the move. We had been building up our previous years' cost reduction plans to create that buffer, knowing that when we moved into the new hospital our cost base would increase, as we had planned and budgeted for. I put on record our appreciation to the Scottish Government for managing that cash flow with us. It has been very helpful. It would be difficult to undertake a capital development of this scale without that flexibility between years. That has worked well for us.

The Convener: You have capital allocations for year A, which you do not fully draw down, on the understanding that you will be able to draw them down in year C.

Jeff Ace: That is right, and we have been using revenue in the same way. We were banking revenue with the Scottish Government that we have now drawn down to allow us to deal with the higher cost base associated with the new hospital. That has been a good example of the Scottish Government working flexibly with the board.

The Convener: That is helpful. We will now move on to staffing issues.

David Stewart: I thank the panel for their contributions so far. Much of what has been said has been about recruitment and staffing, so I want us to drill down into those issues. I glanced earlier at the Information Services Division Scotland consultant vacancy rates. If I have understood them correctly, your board has the highest consultant vacancy rate in mainland Scotland. If you look at figures for more than six months, your board has the highest rate in Scotland, including the islands boards. Members clearly understand the reasons for that, but could you talk more about the board's initiatives to address the extremely high vacancy rates?

Jeff Ace: I will start and then bring in Ken Donaldson, who is leading on the matter. The scale of the recruitment difficulties that we face represents our single biggest challenge. Money keeps me awake at night, but recruitment is the issue that has the most direct impact on our staffing teams and their ability to deliver the quality care that they want to deliver. It is the most urgent issue for the board to fix. I think that we were late to see the scale of the difficulties, and I take personal responsibility for that.

In 1999, when I arrived to do a previous role in Dumfries and Galloway, the board had no difficulty recruiting—we had long lists of applicants for consultant jobs and our GPs did not experience difficulties—so we were slow to realise that the situation was not a temporary blip in recruitment and that a structural change was going on. The issue can be clearly seen elsewhere in rural Wales, England and Scotland. We were slow to

get off the blocks, and I take responsibility for that, but we are moving forward with a raft of initiatives, which Dr Donaldson will discuss.

Dr Donaldson: We are in a different place, and have been for a few years. It used to be the case that it was simply about advertising—whether on Scotland's health on the web, in *The BMJ* or in other journals—but now there are different requirements for finding permanent staff.

Over the last few years I have found—I will explain why I found this out later—that there are fewer people out there applying for jobs and that Dumfries and Galloway sits a little under the radar. A lot of people do not know where we are and, more important, what we have to offer professionally, through our new hospital, and in terms of quality of life. Dumfries and Galloway is a lovely place to live.

We have engaged in initiatives to recruit staff, one of which was to employ a headhunting agency. The initial tender was for five posts—two consultants, two specialist doctors and a GP—all of which, I am pleased to say, have been filled. Working with the agency, I went to Sweden with a few others on a recruitment drive, which was an interesting learning process. There are many doctors in Sweden who are looking to come to the UK, so we had an opportunity to go out and promote Dumfries and Galloway as the place to come to.

We have been involved in international recruitment, mainly through taking a more national approach. That has been really successful for us, particularly in radiology, which is an area that we have struggled with for some time. We have now filled a number of posts, and that has been a real change for us.

Just over a year ago, I went with a team to *The BMJ* careers fair in London, which is where I first realised that a lot of doctors, particularly in England, do not know where Dumfries and Galloway is, or what it has to offer. That was a useful exercise. We went there again just over two weeks ago, this time for an NHS Scotland stand. As part of that, we developed a prospectus, "Work, Live, Play Dumfries and Galloway", which I will pass to members and which we hand out at careers fairs and other events.

We have been active in using social media—in particular Facebook, but also Twitter. Our NHS Dumfries & Galloway Connect account on Facebook has advertised many roles in a pictorially attractive way. One of our local GPs has a Connect account that includes recruitment but is more about promoting Dumfries and Galloway. The front of the prospectus has a lot of pictures of members of staff holding cards that say who they are. Sadly, the GP has used my photo—pictorially, I am not perhaps the best person to use—that says that I am a medical director and talks a bit about why I am in Dumfries and Galloway, including what I like about it and the opportunities there. We have tried innovative approaches such as that to get our brand out there.

As Jeff Ace said, the board needed to sit up and recognise the situation. We have agreed, as a management team, to recruit a local team to deal with recruitment that will do more digital media marketing—how we brand Dumfries and Galloway and how we get the brand out there. That will be similar to what I have described but in a more consolidated and co-ordinated fashion. It will relate not just to medics but to nursing and allied health professionals, which are areas in which we have problems with recruitment.

In the longer term, we are part of the Scottish graduate entry medicine programme—ScotGEM—which we hope will bring in GPs and people who wish to come to the region.

In the even longer term, we are promoting healthcare professions in schools, which means going out to schools, asking young people whether they want to be nurses or doctors and explaining a little bit about what that entails and what we have to offer. Ultimately, I am keen to bring fairly young school students into the hospital setting or into GP practices to show them what is there. It is not just about being a doctor or nurse; there is laboratory work and work in other healthcare areas.

David Stewart: You touched on the scheme with the University of St Andrews, the University of Dundee and the University of the Highlands and Islands, which is in my patch. They make the point that you can retain staff by having a lot of local staff, and the best way of ensuring that is by having connections at school level. It is obvious that places where there are universities that train medical students, such as Glasgow and Edinburgh, are liable to retain them. If you look at the league table, you find that that is the case. However, I will turn to one of your neighbours. NHS Borders has a very low vacancy rate. Although you cannot speak for it, is there any useful way to compare and contrast the two areas?

Dr Donaldson: You are right in saying that the Borders region shares a lot of similarities with Dumfries and Galloway. One slight difference is that the Borders is a little closer to Edinburgh and the Lothians and shares a lot of services, whereas Dumfries and Galloway sits more distinctly on its own. Obviously, we have links with Glasgow, but the geography means we are not really commutable from Glasgow, unless you live at the Lockerbie end of the area. Even from there, it is still a bit of a journey to Glasgow. It is a much easier commute to Edinburgh from the Borders.

However, I am guessing—I do not know whether that is a fact, so perhaps I am being a bit unfair.

Jeff Ace: It is important to realise that often we are asking families to move into Dumfries and Galloway. That often means finding a professional role for the spouse of the individual whom we recruit. In a small economy like Dumfries and Galloway, that is particularly challenging. We look at joint opportunities with the council: if it is recruiting a teacher whose partner is a nurse, for example, we can make those links.

However, for people whose profession is outside the public sector, the private sector in Dumfries and Galloway is relatively small, so its ability to absorb such newcomers is commensurately limited. That might be a slight difference between Dumfries and Galloway and the Borders region, which has Edinburgh in its hinterland. Although, as Ken Donaldson said, we are surmising about that.

We speak frequently with NHS Borders colleagues about what they are doing on recruitment and retention. We are confident that they have not hit on secrets that we have not hit on, but we are keen to learn from whoever is currently successful.

David Stewart: The knock-on effect of having the high consultant vacancy rate that I mentioned earlier is that you have high agency costs. I noticed that the figures have shot up in the past 12 months, which must give Mr Ace more sleepless nights. I understand that. Most of your agency costs are from hiring medical locums.

Jeff Ace: Yes. Traditionally, we have used very few agency nurses, which is slightly different from the pattern across Scotland, although you will see some hot spots. Only in the past 12 months, and last winter in particular, did we start to see gaps in nursing staff that we could not fill. With regard to Ken Donaldson's point, we must make sure that when we reinvigorate our approach to recruitment and use social media much more broadly, we do not focus just on medics, but instead get ahead of the next set of problems around nurses and AHPs. However, David Stewart is right that, at the moment, our agency cost driver is medics.

You mentioned my sleepless nights, which I brought up. We can manage that cost, more or less. That is not what worries me. What worries me is the impact on our teams that are working with non-permanent staff members, who are much less engaged in service redesign and are much less willing or able to take on clinical leadership roles. The impact of using locum staff is more through the pressure that that puts on the residual teams, rather than the financial hit, great as it is.

David Stewart: Many boards that appear before us say that the solution to any problems that they have—most of them are in finance or recruitment—involves two main things: first, what you can do with regionalisation and secondly, what you can do in partnership with national Government.

You have run a lot of interesting and sensible initiatives, such as recruitment fairs and the prospectus about the region. Should national Government run initiatives that could help with your issues?

10:45

Jeff Ace: The west of Scotland regional work is interesting from our perspective, and we have had some successes. We are looking closely at re-aligning our vascular network with the west of Scotland, through our partnership with services in Carlisle. That will give us advantages in relation to sustainability. We have a good partnership with NHS Ayrshire and Arran in urology services, particularly in the west of the region. Some regional initiatives are working for us.

For realism, I will caveat that by saying that the distance and travel times between Glasgow and Dumfries and Galloway, for example, make joint appointments inherently inefficient, because we lose capacity simply because of the M74 travel times. However, we can make progress in some areas.

We would welcome a continued national focus on making it attractive to live in rural Scotland, which should not mean just the Highlands and islands.

David Stewart: We have touched on Brexit, and I am loth to raise the issue in my last question. However, you mentioned that you are discussing Brexit, which will be on your risk register. How significant are employees from the other 27 European Union nations to staffing in NHS Dumfries and Galloway? Beyond that, how significant are employees with tier 2 visas from outwith the EU to your employment status?

Jeff Ace: In conjunction with other mainland boards, we are about to survey staff formally in order to get information on the precise numbers, and we will work with those members of staff on an individual basis. We are lucky in that we are a relatively small system. We know that EU staff are critical to our continued safe working. They have been an integral part of the success of NHS Dumfries and Galloway in primary care, in dentistry and in our acute service. It is deeply uncomfortable to have to survey such individuals and talk to them about their needs.

Emma Harper: You mentioned the difference in travel times, which is an issue even for people within the region who travel from Stranraer to

Dumfries, for example. Digital infrastructure and road infrastructure are issues—we are always bleating that we need to invest in the A75 and the A76. How does the digital and road infrastructure affect attitudes to recruitment? Is that a challenge to which the Government needs to pay attention? Does it need to contribute significantly more to digital and road infrastructure?

Jeff Ace: That would be welcome. If you get a chance to look at our brochure, you will see that we have created a map that demonstrates the travel times to Glasgow and Edinburgh, as well as to Newcastle and Manchester, in order to show that Dumfries and Galloway is not a remote area, as people from England might think. Clearly, anything that can be done to minimise travel times to airports and to minimise delays in accessing fast broadband will increase our offer to individuals, especially those with young families. Digital connectivity is as important to such people as the train commute to Edinburgh, for example. Those issues relate to the offer that we are trying to create; we want people to come and live with their families in Dumfries and Galloway. For that offer to be attractive, we need all those advantages to be lined up, so help would be greatly appreciated.

Emma Harper: Should that help relate to railways as well as the roads?

Jeff Ace: As part of a team that suffered from a train cancellation and a stressful drive this morning, I would appreciate that support.

Alex Cole-Hamilton (Edinburgh Western) (LD): I want to turn the discussion to child and adolescent mental health. Your performance in Dumfries and Galloway is higher than the national average, for which you are to be commended, but it is fair to say that it is still worryingly difficult and represents a declining picture. What are the primary barriers to having children seen within the 18 weeks prescribed?

Julie White: You are absolutely right. I am disappointed to say that our performance in Dumfries and Galloway has deteriorated, but we are starting to see some shoots of improvement, with our latest performance against the 18-week target sitting at 77.6 per cent between April and June.

The challenges that we have had in Dumfries and Galloway have been twofold. Again, it goes back to the recruitment issue. There is difficulty in recruiting to posts, including in our child and adolescent mental health service. We have also had some difficulty in backfilling the posts of individuals who have taken on national roles elsewhere. We might be challenged about why we are not keeping people locally, but we are keen to learn from experience elsewhere. It is about getting a balance between how many of our staff members we keep locally and how many we encourage to learn from experience elsewhere.

We are seeing increases in the demand for our child and adolescent mental health service, but we triage our referrals three times weekly to ensure that children and young people who have the most urgent need are seen as quickly as possible.

We have also introduced a number of improvement projects in our child and adolescent mental health service. We have introduced a primary mental health worker in general practice. That is a mental health professional who works in general practice and receives direct referrals from the GPs of children and young people with mental health problems. That has significantly reduced the demand on our tier 3 specialist mental health service. That pilot has been running for a year. In the practice in which we received the direct referrals, which is one of our large practices, we saw that very small numbers of those children and young people needed onward referral to the specialist mental health service and, indeed, all those children and young people were seen within three weeks.

That sets a target for us in Dumfries and Galloway and, with our new mental health strategy funding, we have identified the development of those primary mental health workers in general practice as a key priority for us. We will extend the number of them across Dumfries and Galloway to improve access to mental health services for children and young people, to reduce our waiting times and to provide early assessment of children and young people. As I said, those children were seen within three weeks.

We have also introduced a mental health worker for urgent referrals in Dumfries and Galloway. That person undertakes urgent assessments of children and young people who present to us with mental health problems—for example, those who have been admitted to hospital following an overdose. Our evidence to date shows that we are able to provide those assessments for those children and young people on either the same day or the following working day using that mental health worker.

Those are some of the improvement projects that we need to roll out. We are confident that we will see some improvement in our performance towards the 90 per cent target but, as I have said, that is coupled with the challenge of our difficulty in recruiting. We have talked about our medical recruitment. Our nursing recruitment is equally challenging, particularly in specialist areas such as child and adolescent mental health services.

Alex Cole-Hamilton: Thank you for that comprehensive response. You clearly seem to have a handle on what is going on.

I want to ask specifically about tier 4 referrals. One of the problems that we have noticed in the country more widely relates to young people who are referred for in-patient support at tier 4 level but are then turned away because there is insufficient staffing capacity to support them. What is the picture in Dumfries and Galloway for tier 4?

Julie White: We have challenges in access to tier 4 services—that is common across Scotland—but we ensure that the level of support that we can provide to those children and young people through the tier 3 service is delivered in as timely as manner as possible to avoid any further escalation of their needs.

I do not have data in front of me on the number of people we have had waiting for tier 4, but I can provide that data to the committee following the discussion today. However, the number of people who are waiting for tier 4 in Dumfries and Galloway is very small.

Alex Cole-Hamilton: Unless any of my colleagues want to come in on CAMHS, I will move on to look at your complaints processes. One of the things that jumped out of the ISD figures was the fact that your response rate for complaints that are responded to within 20 working days is around 55 per cent, which is quite significantly below the rest of the field. Why is that?

Jeff Ace: This has been an issue of contention at our board for some months, or possibly for longer than a year. We have been in the process of revamping our complaints process to deliver something that we think will provide a greater degree of satisfaction for complainants, and I am pleased with the way in which that work is developing, but it has created a process that is not moving quick enough to hit the target. We have made it clear—and the chairman has made it clear to us as executive directors—that we cannot simply sacrifice timeliness for that enhanced quality and our preference for meeting physically with complainants, so we have to square the circle of timeliness and quality and we are pushing hard on that at the moment. You will see those figures improve dramatically over the coming months as we make the system slicker.

To go back to my first point, I am pleased that we turned the system upside down to look at what complainants were receiving from us, how satisfied they were with the complaints process, and what we could do to make that better. That was a good piece of work, but where we have slipped up is in not taking a lean approach to how to do that in a timely enough fashion. We are under great pressure from our chairman and the other non-execs to turn that around, and we will.

Alex Cole-Hamilton: One of the reasons behind my question is that, when it is clear that rates of response to complaints, or complaints systems in general, are suboptimal, it gives cause for concern about other areas where complaints are important. This committee often concerns itself with whistleblowing, which is a contemporary issue in this landscape, particularly in relation to the travails of other health boards. Given the slow response rate that you have for normal public complaints, can you explain whether internal complaints are dealt with appropriately? Are your systems robust?

Jeff Ace: I can give that assurance to the committee. We have a relatively flat management structure in Dumfries and Galloway, and I guess that that is a symptom of being a small system. That allows us to quickly address concerns that are raised, to understand the pressures that staff are under at various levels in the organisation, and to respond accordingly. We have had two whistleblowing incidents in Dumfries and Galloway in my time as chief executive, both of which were dealt with by our established process. I would hope to see no more. I think that whistleblowing is a symptom of internal controls, checks and assurances not working appropriately and a symptom of staff frustration with that.

I would be deeply disappointed if staff felt that they could not raise concerns appropriately, to me, to Julie White, to Ken Donaldson or to their general management level. That would not be the organisation that I have tried to create in my time as chief executive. We pride ourselves on being an open and transparent organisation, and I think that the evidence of our walk-arounds, our individual discussions with managers and their teams and the performance that we have delivered in the light of great pressures is a testament to how our staff are working and how they are working with us.

The Convener: I have a simple question. In relation to complaint handling, do you follow the Scottish Public Services Ombudsman's guidelines?

Jeff Ace: Yes, we do.

The Convener: Thank you very much.

Brian Whittle (South Scotland) (Con): One of the key strategy objectives and aims is shifting resources from acute to community care. What progress are you making in that area?

11:00

Julie White: With regard to shifting the balance of care and moving resources from one part of the

system to the other, I am sure that members are all aware of Dumfries and Galloway's integration scheme as being unique in covering all acute services, all community health and social care services, all primary care services and all mental health services. One of the primary drivers of that approach was to ensure transparency in the use of resources across the entire health and social care system. I am absolutely clear that, as chief officer of the IJB and the health and social care partnership, I have authority over and control of the integrated budget for acute services, community health and social care services and mental health services as well as a range of other services in Dumfries and Galloway.

With the delegation of acute services to our IJB, the board is extremely aware of the significant demand pressures on acute services across Scotland. We are aware of the increasing population of older people and the material demand that people living longer with multiple long-term conditions make on our acute service. In the bed modelling that we undertook for the new hospital, we made some assumptions about the use of acute services in Dumfries and Galloway to ensure that we were able to live within the model, and those assumptions included a reduction in the demand for acute hospital beds and in the length of stay in acute hospital settings. Our projections suggest that the population of older people will increase up to 2035, and we expect that to continue to put pressure on our acute services.

Our IJB, therefore, has focused not on taking money out of acute services but on spending a larger proportion of our total delegated budget on community-based services and on looking at the balance in that respect. Our forecast for the balance of that split is that, by the end of 2018-19, we will be spending approximately 49.8 per cent of our budget on hospital services and 50.2 per cent on community-based services. That, for me, is a significant achievement in Dumfries and Galloway, given what you have already heard about the development of the brand new district general hospital and the additional costs that come with it.

Because of the new hospital, there has also been a considerable increase in expenditure in acute services with the new nurses that Jeff Ace alluded to, the increased number of domestic staff and so on, but I must point out that we look at the totality of the resource that is delegated to us. Some developments might, on paper, look like they are an investment in acute services in Dumfries and Galloway. For example, we have agreed to the recruitment of an additional palliative care consultant, an additional care for the elderly consultant and a new integrated respiratory team. They might look like an investment in acute services, because that is where the budgets for palliative care, care for the elderly and so on sit at the moment, but if we are able to recruit people to those posts—and I should point out that we are having difficulties in recruiting to both the consultant posts that I have mentioned—they will provide services within the community.

I simply wanted to highlight to the committee that split in our expenditure and the fact that our focus is very much on increasing the proportion that is spent on community-based services.

Brian Whittle: You said earlier that the prevention agenda is key to your long-term projections on efficiency. Can you give us any examples of resource starting to shift in that direction?

Julie White: With regard to our balance of care work, we have in the past year spent more than £1 million on a rapid response service for Nithsdale, which is the biggest locality in Dumfries and Galloway. The service was introduced to work primarily with GPs on avoiding unnecessary admissions to and supporting discharge from hospital, and we have received very positive feedback from our general practices on the rapid response team's impact in providing GPs with an alternative to sending someone to an acute hospital.

In addition, at the upstream end, our focus as a partnership is on reablement. We have the STAR—short-term assessment and reablement—service, which is focused on providing inputs and support to individuals to bring them to the maximum level of independence that they can achieve, given their long-term condition or their disability. Last year, more than 1,000 people in Dumfries and Galloway were referred to our reablement service, and 55 per cent of them were discharged from it with no care and support. The service gives them rehabilitation and activities of daily living support; importantly, it also signposts them to other community-based activities and support, which could include things such as walking groups and craft activities, to encourage them to maintain their level of independence at home. We are proud of the outcomes from the reablement service, because we can demonstrate that almost 60 per cent of the people who were referred to it were discharged with no care or a reduction in their care package.

Brian Whittle: You do not retain the set-aside budget. Does that help you to shift resource to such areas?

Julie White: We do not have a set-aside budget because all our acute services are in the partnership. I think that the fact that all our acute services are in the partnership has helped us from the point of view of transparency and being able to understand where our expenditure is and what we are achieving with it. One of the challenges is to

do with how we look at our performance in relation to that expenditure. Having all the acute services in our partnership gives us the opportunity to have open discussions in our IJB about our spend on acute services and how we want that to shift. It is a case not of taking money out of acute services but of increasing the proportion of our spend on community services.

Brian Whittle: You mentioned the IJB. The move towards regional planning is very prevalent at the moment. We have struggled to understand how the roles and responsibilities of the board work within a regional planning arrangement. We do not know who is accountable or where responsibility for decision making on service planning, delivery and performance lies. Could you expand on that for us?

Julie White: I am clear that, when it comes to acute services in Dumfries and Galloway, the responsibility for service planning sits with our IJB. The functions for acute services are delegated to our IJB, so the responsibility for planning at a strategic level sits with the IJB.

However, our IJB has also been actively involved in the discussions on regional planning, because we recognise that the future sustainability of a number of our acute services requires us to be actively involved in regional planning. At local level, we are clear that we have delegated the accountability and planning functions to our IJB. Although it has that responsibility, we are actively involved in the discussions about acute services, because if we are to ensure the sustainability of a number of our acute services, we require to work in partnership across the west of Scotland.

Brian Whittle: Are you saying that the IJB is the accountable body when it comes to the delivery of those services?

Julie White: No. It is the accountable body when it comes to the planning of those services. The IJB is a strategic commissioning body, so it has responsibility for the strategic planning of those services. As the chief officer to that IJB, I am clear that I am accountable to it for the delivery of the strategic plan. However, when it comes to the operational delivery of the delegated services, as the chief officer, I am accountable to two chief executives—Jeff Ace, the chief executive of the NHS board, and the local authority chief executive—for the delivery of those services. I have dual accountability.

Bob Doris: This is a fascinating conversation. I am struck by the performance of NHS Dumfries and Galloway. In our paper, we have a list of outcomes in clinical care and governance that it appears will not be met. I will mention just two of them. The most recent quarterly report suggests that the expected outcomes on, first, the rate of acute emergency admissions per 100,000 adult population and, secondly, the rate of acute emergency admission bed days per 100,000 adult population are unlikely to be met.

I am also looking at the fact that, in August, A and E waiting times performance was 93.6 per cent. Okay, that is not 95 per cent, but it is a strong performance. There has been relatively strong performance generally in that area. Also, 96 per cent of out-patients waited for less than 12 weeks, which is above the national average of 75 per cent. Although you are certainly not there yet on the number of in-patient and day cases that were seen within the treatment time guarantee, the figure was 84.5 per cent as opposed to 74.6 per cent nationally.

It is a mixed bag. I know from when I was a member of the Health and Sport Committee in the previous session of Parliament that targets can mislead as well as inform. There is tension between the outcomes that look as if they are not going to be achieved on acute emergency admissions and some of the good work that Julie White mentioned. I want to get beneath the surface of some of that performance, but I first wanted to put on the record some points about the mixed performance of the integration joint board and the health board.

My substantive question is about the preventative agenda. If someone goes in for cataract surgery or a hip replacement, that can be an acute intervention. However, if a hip replacement is done early rather than after a long wait, that is actually a community intervention, because the person will be enabled far more quickly and will be healthier and safer in their house. When we look at slips, trips and falls among those who have waited far too long for a hip replacement or a cataract operation, we can see that that wait increases the risk and drives up emergency admissions. Those are examples of acute interventions that have direct community benefit. Have you mapped how early intervention through acute procedures has a direct benefit for community enablement and keeping people, particularly among the ageing population, in the community longer? I do not think that the Scottish Government has done that.

Jeff Ace: I am probably going to have to say no to that comprehensive question. It is a great question. We have had discussions about the issue with individual clinicians. I have talked to ophthalmologists about our intervention point with cataracts, which is lower than it is in some other boards in Scotland. That discussion was about the fact that, in a rural community, driving is critical people's ability to get around because of the public transport difficulties that we have touched on, so we need to intervene earlier than other systems

might be comfortable with. However, we do not have a comprehensive map of early interventions.

The point about shifting the balance of care that was raised earlier is a fascinating and fundamental one for the committee. I was interested in the report that you published yesterday. In the lead-up to building the new hospital in Dumfries and Galloway, we did an awful lot of health intelligence planning about who would use acute services given our demographics up to 2035, which Julie White talked about. No matter how optimistic we were, we could not with any certainty forecast that we would cut acute spending in that period. We think that we have taken an ambitious line on our ability to redesign lengths of stay and admission rates so that we can hold within that acute footprint, but we are not planning for a significant and substantial shift of resources out of acute and into the community, because our health intelligence models say that our population will continue to demand hips, knees and so on and to require trauma services. When we model the relationship between older people, particularly the over-85s, and hospital bed use, we cannot see a smaller DGRI than the one that we have now.

When people talk about shifting the balance of care, we need to tease out exactly how, with a system that works on about three beds per 1,000 population—which is at the very low end of the European average—they intend to take out that large amount of resource to feed into community services. That is a profoundly important point for the future planning of health services in Scotland.

Bob Doris: I promise that there is no preamble to my supplementary question, convener.

Julie White could make a case and say that, for community purposes, she wants more hip, knee and cataract operations at a much earlier stage than clinicians might be able to grant them. Perhaps some acute expenditure could be transferred over and presented as a bid from community services to drive community outcomes. Would you perhaps map that in your next annual report?

10:15

Jeff Ace: We could map that. The beauty of our system is that Julie White controls the expenditure on all aspects of health and care. In the hand that we have been dealt, we are coterminous with the council, so we have been able to take the unique step of putting in all the acute services. That gives us a unique advantage, in that we are able to take that holistic look, and we do not see a sterile competition for resource between community and acute services. Those of us who are old enough to remember acute, community and primary care trusts know that it is an utter waste of everybody's time to fight over resources, when we should be collaborating and the patient should be at the centre. We have a unique service model because of our advantages—from which we can begin to demonstrate some gains—compared with the more complex models that are necessary elsewhere because of overlapping borders and so on.

Bob Doris: Could early acute intervention that supports community enablement be presented as part of the community budget, for example? Could you perhaps do that in the future?

Julie White: Yes.

Jeff Ace: Certainly. A paper that was written by our public health team went to our board in June. It looked at the interventions with the biggest impact from a public health perspective that would avoid the decline of individuals into frailty. Key among those—the top interventions—were work on falls prevention and physical activity for all ages in the population. That fits with your question about the point at which we intervene, and how we intervene successfully, to avoid further frailty.

Bob Doris: That is helpful.

The Convener: I am glad that Jeff Ace referenced our report, which was published yesterday in advance of the budget. Clearly, you have gathered that the committee is supportive of the shift in the balance of care but that we are also aware of the challenges in making that happen.

Julie White talked about being accountable to the IJB for the creation of the strategic plan, and being accountable to the NHS board and the local authority for the delivery of that plan. How comfortably does that sit with the situation in which, presumably, she is employed wholly by the NHS and not at all by the local authority? How does that work in practical terms?

Julie White: In practical terms, rather than having a one-to-one meeting with Jeff Ace on my performance, I have reviews and then a one-to-two meeting with two chief executives. I regularly meet the chief executives to discuss areas of operational concern and my performance in relation to objectives and so on. On a practical level, that works well.

As Jeff Ace said, we have been dealt quite a fair hand in Dumfries and Galloway. We are a fairly small partnership, and our boundaries are coterminous with the local authority's boundaries. We have taken the opportunity that that creates to develop an integration scheme that is as robust as it can be with the inclusion of all our acute services.

At a personal level, I feel comfortable about my accountability to the two chief executives for the operational delivery of services, and I am clear

that I have accountability to the IJB for the strategic plan and its delivery. In practice, that normally works through regular meetings with the IJB chair. In Dumfries and Galloway, we have strong leadership from our IJB chair and vice-chair—with whom I also have regular meetings—to push forward with the integration agenda. I present performance reports each quarter to the IJB to give it assurances about the delivery of the strategic plan.

The Convener: I believe that Dumfries and Galloway is one of the councils in rural Scotland that has talked about joining forces with its local health board to form a single entity. Is there a response to that proposition from NHS Dumfries and Galloway?

Jeff Ace: I was not aware of that. [*Laughter*.]

The Convener: Perhaps I am anticipating what will come next.

Jeff Ace: Several years ago, we discussed a scheme in which councillors could act as non-executives on the health board to create greater linkage.

My view is that we are using the IJB vehicle as effectively as it can be used in Dumfries and Galloway. With the gains that we are seeing for patients and families, we can demonstrate that things are improving and that we are generating improvement. I would be loth to look at a further structural change that would delay us from getting on with what is really important.

Miles Briggs (Lothian) (Con): I want to ask about drug and alcohol services in Dumfries and Galloway. Looking at your 2016-17 budget, I see that you were asked to fill a shortfall of £452,000 after the Scottish Government made a 20 per cent cut to funding for alcohol and drug partnerships. Your accounts suggest that you filled £234,000 of that shortfall. What impact did that have on service provision in the area?

Jeff Ace: We were able to match the amount that we had spent previously, although, as you noticed, our budget was greater than previous spend. We had a degree of unallocated expenditure and we were about to go into another grant round, so we did not see significant reductions in the services that we provided. However, drug and alcohol services are an area of particular focus for us. We have seen an increase in the number of drug deaths in Dumfries and Galloway, which is an area that the alcohol and drug partnership is working closely on.

I will bring Julie White in on the detail.

Julie White: I echo what Jeff said. We were able to match the funding for what we were previously commissioning, so we did not have to reduce the level of commissioning or stop services as a result of not receiving the full allocation. We were in the process of developing a new commissioning strategy in the alcohol and drug partnership. We have taken an innovative approach this time—what we call a co-production approach with service users, their families and carers. We looked at what matters to them in drug and alcohol services and they helped us to identify our priorities for commissioning.

We are now in the process of going out to tender for a number of our drug and alcohol services, and that co-production work helped us to prepare for the additional £505,000 of Scottish Government funding that we received recently. The work has given us some indicators of what matters to people in Dumfries and Galloway and what services we should commission. Family support is of particular importance. Instead of providing support just to the person who is affected by drug or alcohol misuse, we provide support to the families, carers and young people who are affected by it.

We have been working closely with partners in the third sector on how we can commission a family support service. Our alcohol and drug partnership brought a report to our most recent IJB meeting, which outlined our annual performance and our priorities for the £505,000 investment. We pass all the resources that are given to us for alcohol and drugs work to the alcohol and drug partnership, and it works with our partner agencies and with service users and their families and carers to identify priorities in using those resources.

Jeff Ace mentioned drug deaths. The alcohol and drug partnership noticed that 2017 saw the highest number of drug deaths in Dumfries and Galloway that we have seen in recent years. We have a drug death group that meets regularly and reviews every drug death to see what learning can be gleaned from it. We have not noticed any common themes from the increase in the number of drug deaths except for an increase among the older population of drug users. We need to focus on that increase in deciding what initiatives to undertake with the £505,000, but I do not have the plan for that because we are still working it through with the alcohol and drug partnership.

We are also aware of a need to improve our delivery of alcohol brief interventions, which is a key priority for the alcohol and drug partnership. We need to increase the number of interventions in acute and primary care settings, and we are working with colleagues in both of those settings to see how we can do that. We think that a number of alcohol brief interventions are taking place but that we are not recording them appropriately in the system.

That is a summary of where we are at with alcohol and drugs work.

Miles Briggs: Thank you. It is useful to hear of the plans that you have outlined. One fact that jumped out at me is that NHS Dumfries and Galloway has the highest percentage of drug-related hospital admissions. It is at a crisis point. Is that somewhere for the new work that you have outlined to start cross-referencing?

Julie White: We are looking at what support we can provide around prescribing, which is part of the reason for the number of drug-related hospital admissions. We will consider what further action we need to take to reduce the number of hospital admissions resulting from drug and alcohol misuse.

Emma Harper: You mentioned co-production and talked about the preventative agenda and signposting. I recently attended a transforming Wigtownshire event at which people were using the term "co-production". I am curious to know what that means. The people in the Rhins and the Machars of Wigtownshire want to be sure that they are working together and not being telt what is going to happen to them. I am curious about the co-production issue.

Julie White: I appreciate that, and I apologise for the use of language that some people find unhelpful. I echo the concerns of the people of Wigtownshire about the use of that language.

Co-production is effectively about our working with people to design the shape of our future services. It is about looking at how we work with our local communities, having an honest conversation with them about the risks, challenges and possibilities in the future shape of services and genuinely engaging with them. It is not about the statutory services or our partners in the third sector coming up with new ways of working and then consulting people on them. With co-production, the communities and people whom we serve are involved in the development and design of the future shape of services.

In Wigtownshire, we are working really hard to get out there and engage with our communities. I am talking not just about the traditional ways of engaging with elected members and community councils but about getting out there and talking to people in our communities about what matters to them and about the challenges that the health and social care system is facing so that they can work with us on the design.

We recognise that difficult decisions will have to be taken in the future. We have talked about the financial challenges and the recurring financial deficits that we face. Some difficult conversations will have to take place, and we feel that our best chance of success in delivering new ways of working is to have the community involved with the design right at the outset. That is what we mean by co-production.

Sandra White: I am interested in the point about drug deaths among older people. Obviously, they have other issues. It is the same in Glasgow and the west.

I have a point to make about alcohol. I was on the board of an inquiry, and most of the people who had problems with alcohol, or who suffered alcohol-related deaths, were aged 55 and over. Have you found that? A lot of the problem was to do with loneliness and isolation. People were not going out; they were buying drink and drinking it in the house. Have you seen that?

Julie White: I do not have the figures, but we know that older people who experience loneliness and isolation can turn to misusing alcohol as a result. We are doing a piece of work in our communities to address loneliness and isolation among older people to promote their engagement with other community activities. I do not have any details with me of the number of service users and their admissions in relation to alcohol, but I can provide that information to the committee after the meeting.

Keith Brown (Clackmannanshire and Dunblane) (SNP): I congratulate you on the hospital. It forms no part of the brief that we have today, nor of the Audit Scotland report, but it is a remarkable achievement. Parliament is not good at recognising when things have gone really well and learning lessons from them, so I just wanted to say, "Well done."

Two issues around Brexit have been mentioned. I appreciate that recruitment is about to feel the impact of Brexit. However, you also mentioned the cost of medicines, and I think you said that coming out of the EMA could mean a three or four-times increase in the cost of medicines. You also mentioned that New Zealand can sometimes have cheaper prices but it does not have the infrastructure of drug and pharmaceutical companies that we have in Scotland. Is there scope to work more with the pharmaceutical companies, which have a massive effect on the economy, by coming to some agreements with them that recognise their contribution and allow them to be more certain about the business that is coming their way?

The situations in the south-west and north-east of Scotland are fairly unique. Surely we should use that to our advantage to mitigate what seems to be a chilling prospect of a three to four-times increase in costs.

11:30

Jeff Ace: Yes. I was referring to particular products, not looking across the board. If we are in a deal scenario for Brexit and we have a transition period, that type of negotiation could be productive. The concern for the health service at the moment is primarily the no-deal scenario of a hard Brexit on 30 March 2019, which would make it quite difficult to replicate our current supply line arrangements. The price that we would be able to buy products for would reflect our desperation for those products. There is a real concern about a no-deal scenario and our ability to provide business-as-usual services in that context.

Keith Brown: I understand what you are saying about the two different scenarios, and I am not sure about waiting until we find out how bad Brexit is going to be. The idea is to recognise the drug companies' contribution to the economy in some way that allows you to strike a deal with them. I appreciate that it would be a deal not just with your NHS board but across Scotland—perhaps across the UK. I am asking whether there is scope to address what seems to be a big problem for you guys.

Jeff Ace: There could well be scope for that. That is an optimistic and positive way of looking at the future relationship. I guess that we have to look at the reality that we are moving from being a large purchaser of drugs to being a smaller purchaser with a commensurately deteriorating bargaining position.

These are manageable problems, and talking about them as potential opportunities is exactly the right way to look at the situation. The issue that is making health services across Scotland very uncomfortable is the 30 March deadline and our not having the ability to work as you suggest.

The Convener: I thank our witnesses for their evidence, which has been helpful. You have offered to provide some more information after the meeting. I noted down the CAMHS tier 4 alcohol action plan and the work on loneliness, as well as something on the recurrent and non-recurrent savings as that issue becomes clearer. We might have one or two more questions, which we will put in writing after we have had an opportunity to discuss them. Thank you for your attendance this morning.

11:33

Meeting continued in private until 12:20.

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