OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 1 November 2016

Session 5

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Tuesday 1 November 2016

CONTENTS

	Col.
NATIONAL HEALTH SERVICE RECRUITMENT AND RETENTION	1

HEALTH AND SPORT COMMITTEE
9th Meeting 2016, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Clare Haughey (Rutherglen) (SNP)

COMMITTEE MEMBERS

*Tom Arthur (Renfrewshire South) (SNP)
*Miles Briggs (Lothian) (Con)
Donald Cameron (Highlands and Islands) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Alison Johnstone (Lothian) (Green)
*Richard Lyle (Uddingston and Bellshill) (SNP)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Maree Todd (Highlands and Islands) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jim Cannon (North of Scotland Planning Group)
Ron Culley (Western Isles Health and Social Care Partnership)
Stuart Fergusson (Royal College of Physicians and Surgeons of Glasgow)
Trisha Hall (Scottish Association of Social Workers)
David Hogg (Royal College of General Practitioners)
Sian Kiely (Royal College of Nursing)
Caroline Lamb (NHS Education for Scotland)
Adam Longhorn (Allied Health Professions Federation Scotland)
Dr Donald Macaskill (Scottish Care)
Bill S McKerrow (Scottish School of Rural Health and Wellbeing)
Gill McVicar (NHS Highland)
Candy Millard (East Renfrewshire Health and Social Care Partnership)
Gillian Smith (Royal College of Midwives Scotland)
Jill Vickerman (British Medical Association Scotland)
Dave Watson (Unison Scotland)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 1 November 2016

[The Convener opened the meeting at 10:00]

National Health Service Recruitment and Retention

The Convener (Neil Findlay): Good morning, everyone, and welcome to the ninth meeting in 2016 of the Health and Sport Committee in session 5. I ask everyone in the room to ensure that their mobile phones are on silent. It is acceptable to use mobile devices for social media, but please do not take photographs or film proceedings.

We have received apologies from Donald Cameron.

Agenda item 1 is two round-table discussions on recruitment and retention in the national health service. The first panel will focus on general recruitment and retention issues and the second will focus on rural recruitment and retention.

I welcome everyone to the committee. I am the committee's convener and an MSP for Lothian. I am not going to introduce the cast of thousands round the table—you are going to do that yourselves. I ask everyone to give a brief introduction—not your full biography, please.

Trisha Hall (Scottish Association of Social Workers): Good morning. I manage the Scottish Association of Social Workers. We are part of the British Association of Social Workers, which is a United Kingdom-wide body. We are a membership organisation.

Clare Haughey (Rutherglen) (SNP): I am the committee's deputy convener and the MSP for Rutherglen.

Tom Arthur (Renfrewshire South) (SNP): I am the MSP for Renfrewshire South.

Adam Longhorn (Allied Health Professions Federation Scotland): Good morning. I am a paramedic, but I am here representing the Allied Health Professions Federation Scotland, which is an umbrella organisation that gives some leadership for allied health professional bodies.

Miles Briggs (Lothian) (Con): I am a Conservative MSP for the Lothian region.

Caroline Lamb (NHS Education for Scotland): Hello. I am chief executive of NHS Education for Scotland. We are responsible for postgraduate training of doctors, dentists, clinical psychologists, pharmacists and others, and for providing continued educational development for nurses, midwives and healthcare supporters—indeed, anybody who works in or with NHS Scotland, including in social care.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning. I am the Liberal Democrat spokesperson for health and the MSP for Edinburgh Western.

Alison Johnstone (Lothian) (Green): I am an MSP for Lothian and the Green Party health spokesperson.

Sian Kiely (Royal College of Nursing): Hello. I am knowledge and research manager for the Royal College of Nursing.

Richard Lyle (Uddingston and Bellshill) (SNP): I am the MSP for Uddingston and Bellshill.

Dave Watson (Unison Scotland): I am head of policy at Unison Scotland.

Maree Todd (Highlands and Islands) (SNP): I am an MSP for the Highlands and Islands and am also a pharmacist.

Jill Vickerman (British Medical Association Scotland): I am national director in Scotland for the British Medical Association.

Ivan McKee (Glasgow Provan) (SNP): I am the MSP for Glasgow Provan.

Candy Millard (East Renfrewshire Health and Social Care Partnership): I am from East Renfrewshire health and social care partnership. Although we have been a health and social care partnership for only a year, we have been integrated for 10 years.

The Convener: Colin Smyth will likely join us. I assume that he has travel problems.

We will move directly to questions. We have a large round table this morning, so brevity in questions and answers will be rewarded—not with anything in particular, but with more questions.

I will open the discussion. In the witnesses' experience, have things been improving or going in another direction over the 10 years or so since a previous health committee looked at the issues?

Jill Vickerman: It is fair to say that things are definitely going in the other direction that you mentioned. In thinking about the medical workforce and focusing on recruitment and retention across the range of branches of practice, we need to consider general practitioners—I know that you have heard quite a lot about them recently—consultants, doctors who work in hospitals who are not consultants but are qualified specialty and associate specialist doctors, and even trainees. Among each of those groups, we

are seeing growing numbers of long-term difficult-to-fill vacancies, and we are increasingly having problems filling a range of specific roles for trainees, which is a particular concern. We see a number of reasons for that, but none of them is being tackled yet.

In the past 10 years, there has been increasing understanding of the challenges across the national health service, and of the reasons why posts are increasingly hard to fill and why supply has been slowing down. The main issue, however, is that we have not yet managed to turn that around and take the action that will stem the tide.

As a direct—and shortish—answer to your question, there is no question in our minds: things have got worse in the past 10 years. Possibly the only positive thing to say is that understanding has got better.

Dave Watson: I agree. Things are getting worse, as the available data demonstrates. We have to acknowledge that although data in the NHS is pretty good, it is pretty poor in social care. There is a heavy reliance on registration data, which has a lot of gaps in it—for the obvious reason that the provider area is very fragmented.

However, we know from the array of NHS data that we have an increasing vacancy rate in key areas, and not just in nursing, where the big numbers are—there are proportional problems in occupational therapy and other areas. We also know from the limited social care data that there are particular problems with vacancies—there are thousands at the moment—for social care workers, who need to be recruited to free up the NHS.

Linked to that, we have problems with turnover. To be frank, turnover rates in some of our social care organisations are so bad that they would make call centre operators blush. The figure is 25 per cent and higher—and that is for some of the better employers. Things are also getting worse in that we have an ageing workforce, which brings its own challenges. That is all before we start to recognise the future demand that we will have from a growing elderly population.

Sian Kiely: I echo the points that colleagues have made so far. Nursing vacancy levels are increasingly a matter of concern: recent figures show that vacancies in nursing have gone up again to 4.2 per cent and, worryingly, more than 600 of those posts have been vacant for more than three months.

We would also echo the points that have been made about the retirement age. There has been increasing effort spent on looking at the potential for recruitment over the next five to 10 years. The age profile in nursing—by which I mean nursing and health and social care—is increasing. Ten years ago, perhaps 40 per cent of the nursing workforce was aged 45 and above, but now well over half the workforce is. Future retirals are now of real concern, given that in the past number of years numbers of newly graduated nurses have been at their lowest level since 2002. Many lessons can be learned from how we might use workforce planning to improve the situation.

Adam Longhorn: Allied health professionals would certainly echo many of the comments that have been made, but we add that the data is not particularly reliable for AHPs. After all, they work in private settings, in public settings and in the third sector.

Moreover, vacancies do not tell the whole story. We share the views that have been expressed on the ageing demographic, but I point out that the large change in the staff demographic to its being a largely female staff complement has brought with it interesting challenges.

Workforce prediction tools that reflect where we are going with the workforce—rather than our simply replacing vacancies like for like—are absolutely vital for us. I hope that, later on, I can give the committee a number of examples of where we can use such tools.

Particular challenges with downgrading of staff roles in bands 8 and 7 are disincentivising recruitment and retention. There is also a particular challenge for a number of the smaller professions that we have, which find it difficult to get a clear idea of what the challenges for them are and to move forward to remedy that.

Caroline Lamb: The convener asked us to reflect on the past 10 years, but in doing so, we have to be really clear about the context, which has changed considerably over that time. For example, we have seen huge growth in the population of more elderly people. Over the past 10 years, the proportion of Scotland's population that is over 65 has increased by something like 35 or 36 per cent. There have also been changes in the way people want to work: a new workforce is coming through that is much more interested in working part time and is looking for much more flexibility in how it works.

Also, with regard to medical recruitment in particular, there has been a move away from visa-free training. Ten years ago, we had about 4,000 applications per year for medical training from people who required visas. That number has dropped to something like 400 a year. We have to be clear about the context, because the landscape is changing rapidly.

I should also highlight some opportunities. For example, the national clinical strategy sets out a framework within which we can start to think about delivering services in a way that is much more

sustainable and which provides a really good environment for us to be able to attract, recruit and retain people in the workforce. The announcement of additional medical student numbers is very much to be welcomed. We also need to look at the contribution that all our professions can make—for example, there are some really great examples of pharmacists working alongside GPs in practices.

I agree that we are in challenging times, but there are many opportunities for us, too.

Trisha Hall: Our social work intelligence suggests that recruitment of qualified social workers has not really been a problem; instead, retention is increasingly a problem. According to what people tell us, a lot of that is due to working conditions. Those include hot-desking, not being able to speak to other people and having to book a desk—in rural areas, the nearest desk could be 32 miles away. Last week, a colleague told me that he now spends a third of his week trying to find a desk at which to work. People are also having to work in a far more target-driven culture than social work has traditionally been used to, which is a particular issue for adult care social workers who are working in health contexts.

Integration is nothing new—social workers have always done it. We are talking about what is still a very dedicated and passionate workforce. Last week our mental health officers conference had representation from all 32 local authorities, and it was really encouraging to hear what people had to say about the positives. However, with regard to the negatives, people leave their jobs because of isolation and because they want to do relationship-based work but end up having to write reports instead.

We have some very passionate champions. For example, Dr Morrow from the Mental Health Tribunal Scotland is always advocating the need for social workers to do reports and has made it clear that such work cannot be driven down to a lower, so-called cheaper, level. For us, then, the major issue is not recruitment, but retention.

The Convener: I think that Sian Kiely said that nurse recruitment—or it might have been training—is at its lowest level. Can you repeat the point, because you said it quite quickly.

Sian Kiely: Of course. The outputs of graduating students coming out of university have been at some of their lowest levels in the past few years, and that goes back to decisions that were made some time ago. For example, in 2010-11 and 2012-13, there was a cut of about 20 per cent in nursing student intake numbers, and we are now living with the consequences of that. In recent years, we have had the lowest numbers of graduating students coming out into the workforce. There are five years between the point at which such decisions are made and the point at which a newly qualified nurse enters the workforce and gets subsequent training and experience in order to take on more experienced roles.

At the moment, we are at the crisis point from decisions that were taken some time ago and which, at the time, were the result of employers being under incredible financial pressure and flatlining their projections for nursing without considering how many nurses would be needed to provide care, or the actual numbers that would be needed to enhance the service and to provide different services. The lower intakes that we are experiencing now are a result of workforce planning decisions that were taken some time ago.

Alison Johnstone: I will direct my first question to Jill Vickerman, if I may. Both the BMA and Western Isles NHS, from whom we will hear in the next panel, have highlighted a lack of clarity around data on recorded vacancies. We are clearly in very difficult and challenging times when it comes to recruitment and retention, but it would help us if we knew what the challenges are. The BMA and Western Isles NHS have highlighted discrepancies between the actual number of vacancies in local services and Information Services Division's vacancy statistics, which define a vacancy as a currently advertised post and do not include unadvertised positions or those that are filled by locums. What would be the ideal situation?

10:15

Jill Vickerman: Thank you for the opportunity to pick that issue up. That is a serious concern for us on a number of levels. There is now a reasonably wide understanding that the ISD definition of consultant vacancies is narrow. ISD asks health boards to return specifically the number of posts that are currently advertised. We understand the rationale for having a consistent definition across all health boards, but their realities on the ground are different, so if we are to understand the scale of the problem and tackle it we need to measure the complete picture.

Another effect that we see is the impact on people who deliver front-line services of being told that there are, for example, only two or three vacancies when they can clearly see that there are 10 posts that are not filled by permanent staff; they may have somebody coming in on a locum basis occasionally or the posts may just not yet have been advertised. That has a negative impact on morale and causes a genuine sense of people being even more put upon in the workplace.

It is, for a number of reasons, crucial that we solve the problem. I suspect that if we change the vacancy figure that has been collected and

published for a number of years, we will have to have a difficult conversation about how to get over the political hurdle of how to present it. We need collective agreement about how we measure and describe the posts that are not properly, fully and permanently filled, alongside and in addition to the specific and narrow definition of vacancies that is currently used.

Alison Johnstone: If we describe the vacancies honestly, it will make the situation look worse than it is in the figures that are currently published.

Jill Vickerman: That is absolutely right—but the situation is worse than the figures that are currently published.

Alison Johnstone: Is that why there is reluctance to get to grips with the issue?

Jill Vickerman: That must be one of the hurdles. In the discussions that we have, we talk about how we would overcome the challenge of there being a step change in the number of empty posts that we describe. It is really important for colleagues around the table to think about how we could support that change, because if we do not find a way over that hurdle—politically as well as practically, in terms of defining the measures—we will not have a complete understanding of the reality.

Alex Cole-Hamilton: My question is a direct corollary to Alison Johnstone's question and Jill Vickerman's response.

There is also a problem with training places. We often trade blows in the chamber with the Cabinet Secretary for Health and Sport and the First Minister about the number of GP trainees who are on stream and how many vacancies there are in the GP workforce. That is a thin veneer because we do not get to interrogate whether those are full-time trainees—whether they will go into full-time, or into eight-session or nine-session places—or whether they will practise in Scotland when they finish. We understand from the Royal College of General Practitioners that by the end of the decade we will have as many as 800 fewer GPs than we require in the health service. Audit Scotland's report last week was telling in that it said that our workforce planning cycle in NHS Scotland and, by extension, in the Scottish Government, is over five years, whereas it takes seven years to train a GP.

I ask Jill Vickerman and the other witnesses to reflect on how we can get the right information to establish how deep the training problem is—that is, how many more people we need to encourage into GP training places—and what workforce planning they would like to see in the wider health sector so that it is fit for purpose.

Jill Vickerman: That is quite a wide-ranging question. You focused specifically on GPs and GP trainees, but some of that is obviously relevant across a wider range of medical training posts and, no doubt, a wider range of health professionals.

We answered Alison Johnstone earlier on consultant vacancies. We have better information on consultants than we have on most other branches of medical practice and health professional groups. We also have in Scotland better information than is available in a number of other countries. There is a major challenge: if we are to understand the depth of the problem, we need to get over aside the hurdle of being honest about the data and get on with measuring it. Scotland is not such a big country—it should not be impossible for us to get our heads around the actual numbers of people in post and the number of vacant posts. Our call consistently is that we get better at measuring the reality on the ground across all the different branches of practice.

Quite a bit of work is taking place in the Government on how we can improve workforce planning across health and social care. Caroline Lamb mentioned the national clinical strategy. There is clearly a big piece of work for us all to be involved in to change the way in which healthcare services are delivered throughout Scotland over the next five, 10 or 15 years: planning a workforce to deliver a different health service in 10 or 15 years is a major challenge. As Alex Cole-Hamilton said, the lead-in time for training a GP is a minimum of seven years. For many other medics, it is nearer 10 years. We need to understand now what the future model of healthcare will look like because everybody is committed to changing it such that we provide the workforce to create a sustainable healthcare service. If we do not move quickly to get clarity on what that new delivery model will look like, we will not be able to train the right workforce now. We need to start to do that.

Our call is for a consistent and concerted approach to the future of healthcare service delivery and, as a result of that, that we quickly move on to thinking about the implications for the workforce, what people we need to train and how we enable them to take on the different roles that we are establishing for that future health service.

Ivan McKee: I will ask about what has happened in the past and where we need to go with workforce planning. You are right that it covers more than doctors; it covers the other healthcare professions as well. Therefore, it would be interesting to get a range of inputs on it.

Having done workforce planning in business in a previous life, I know that it is not rocket science: we plug all our variables into a spreadsheet, it tells us what will happen and then we tweak it as we

go. We talk about the fact that there are many variables, but we know what they are. We have to make some assumptions, but we always get feedback on how those variables track over time so we can tweak the model.

From the outside, workforce planning does not seem a difficult thing to do. Given the importance of it, the question is whether it has been done in the past at a national level. Is the situation that we have at the moment an accident of things that happened in the past or has there been any kind of plan or design to it?

Caroline Lamb: I will comment on the supply side of the workforce because we have good data on that, but I will comment first on tweaking the variables.

Over the past year or so, some work has been done on the profile of the workforce in individual medical specialties, examining consultant numbers and likely retirals. There are differences between the profiles of the specialties. More trainee paediatricians tend to be on maternity leave and working less than full time, which might be quite a different profile from those of some of the other medical specialties.

That work is helping to improve the sophistication of our planning for the specialty training numbers that we have in the system for medicine. However, getting the right supply through to fill those spaces is a separate and different challenge. That has to start not only at university but before university. We need to ensure that the sort of kids that we want to be doctors have the aspiration and opportunities to become doctors.

In Scotland, we currently have more medical undergraduate students and more registered doctors per head of the population than the average throughout the United Kingdom but our medical schools have about 50 per cent Scottish university students and it would be good if that proportion were to increase slightly.

One of the advantages of the new numbers that have been announced is that they are focused on widening access, which is really important. The proposals for the graduate medical school will also help to ensure that we are getting Scottish students, who are more likely to stay in Scotland once they have completed their undergraduate training and gone through into specialty training to become the consultant workforce of the future. We know that the main thing that drives where people choose to work is their family and friends, and that is based on where they grew up.

Adam Longhorn: I will pick up on everyone else's comments and I thank Alex Cole-Hamilton for the question. We must ensure that we have robust data around what the workforce looks like and where it stands. It is vital that we look to the models that can provide the service that we need to deliver.

In primary care in particular, we have examples of occupational therapists, podiatrists, chiropodists, physios and radiographers returning to the workforce and providing fantastic services that are, in some cases, provided by GPs currently. We have examples of paramedics replacing GPs one to one in surgeries in Aberdeen. Looking at the entire system and at the acuity of what the staff can provide allows GPs to do GP work. Those novel solutions are working very well.

Dave Watson: When I worked in the health department on secondment for a couple of years, I did some work on workforce planning. A colleague who was working full time in that area described it as more of an art form than a science, which was probably pretty accurate at the time. We have done a lot of work on that. Part of the problem is that the data is variable. I accept Jill Vickerman's points on some of that but data in the NHS is the best we have got; the data in social care is very poor indeed. It is based largely on registration and all sorts of assumptions and definitions that are made there that do not help a great deal with workforce planning.

The problem for workforce planning is that there is a wide range of variables, many of which we can at best only make assumptions about at this stage, particularly when we are talking about five or 10 years ahead. It is not like in other areas of workforce planning, when we can look at a relatively short period. For example, if a workforce planner can take account of the state of the economy, they are probably earning millions of pounds in the City of London and not sitting on a civil servant's salary.

There are therefore factors in relation to the economy, but we also do not know whether we are going to make progress on gender segregation. In the social care sector, only 15 per cent of workers are men; we are clearly not going to be able to tackle the on-going problems unless we address gender segregation.

We also have changing delivery models, not all of which are fully understood, and the pace of change is also not understood. How quickly will we move from acute to primary care services? The Government wants to do that and it is absolutely right, but the speed of that change is going to be pretty challenging. How much can we deliver through changing or expanding roles? We have seen it in nursing and the point has been made about paramedics and others. There are opportunities. A couple of weeks ago, we published a skills charter that shows ways in which the change can be expanded and done more

quickly. That is even without entering Brexit into the calculations.

All that means that the situation is challenging. We could do better, but we need to recognise that there are lots of variables that we do not know too much about.

Sian Kiely: On workforce planning, the RCN has been focusing on ensuring that the wider health and social care workforce is considered. So far, a lot of workforce planning has concentrated on the NHS. In planning for future nursing places, the focus has very much been on NHS employers, but it is important that the wider aspects are looked at, such as the third sector, care homes and the whole arena in which nursing and healthcare support workers are working. I note that the committee will hear from Scottish Care later in the meeting. We are aware of very high levels of vacancies in the care homes sector and it is important that workforce planning for nursing looks at the breadth of employer areas, makes sure that we are planning for health and social care integration, and looks at the places where nursing will be needed in the future.

Alison Johnstone: I would like to ask Caroline Lamb for a bit more information on the refugee doctors programme. Clearly, Brexit has implications for what we are discussing, but I thought that the refugee programme sounded very positive.

10:30

Caroline Lamb: It is very positive. We have been running the programme for a while. It is aimed at supporting refugees who have been working as doctors in whatever country they come from and getting them into employment in NHS Scotland. I do not have the figures to hand, but I can certainly get them for you if you would be interested.

It is important to engage the full breadth of the talent that we have in Scotland in the workforce, and that includes getting people who have those skills and abilities back into the workforce. People might have trained in Scotland but, for whatever reason, taken a career break. We also run a number of programmes that are aimed at encouraging people back into practice—GP returners, dentist returners and nurses. We have been very successful in the past year in recruiting about 145 nurses into our return to practice programme. That is also very important—people may choose to go out of the workforce, but we need to get them back in.

Richard Lyle: I have another question for Caroline Lamb, following on from Ivan McKee and Alison Johnstone's questions. How many training places do we have in Scotland? I think that you made the comment that anyone who is in Scotland should be allowed to train. I have a case where a chap wants to train as a doctor, but I cannot get him in. How many people are rejected? How many applicants who apply do not get in? The Government has said that it will bring in another 50 medical school places—should we make that 250?

Lastly—if you will allow me, convener—I discovered that, when anyone finishes their training, they can immediately leave and go to Australia, New Zealand, Canada or wherever. Should we have a tied-in contract so that people have to stay here for five years before they can leave?

Caroline Lamb: There are a number of questions there. The first was about how many applicants we have. I think that you are probably asking about the undergraduate stage, at the start of somebody's career as a doctor. It is the case that all undergraduate courses in medicine are oversubscribed. It remains a very attractive subject to study. It is at the universities' discretion how they apply their application and selection processes and I am sure that they would guard their academic independence around that very carefully.

It is clear that we do not have a problem attracting people to medicine. The Scottish Government is encouraging universities to look at the additional student places, particularly in relation to widening access for people from different backgrounds. That is a very positive step, which we should encourage.

The numbers issue is a difficult one. We probably need to look at how to do as much as we can to retain doctors in Scotland. We are talking about young people who have lives and have ambitions and aspirations to do lots of different things. Some of them may decide to go abroad, but many of those will then return and come back into NHS Scotland, bringing with them a wide range of experience that will benefit NHS Scotland. Training programmes for doctors are so long that it is quite hard to be prescriptive about what we allow people to do within that. We need to retain as much flexibility as possible.

Richard Lyle: I am sorry to press you on this, but you did not give me an answer to what I was asking about the number of training places. Maybe you want to come back to us on that.

Caroline Lamb: I am sorry; I missed that bit. I can give you rough numbers. We have around 5,500 postgraduate training places, which is the element that my organisation supports.

Richard Lyle: In Scotland?

Caroline Lamb: In Scotland, yes.

Richard Lyle: How many of those 5,500 people leave during the course of the training programme? Is it 5, 10, or 20 per cent?

Caroline Lamb: I am hesitating not because I do not want to answer your question but because it is very complicated. The training programme is split. Doctors do two years in a foundation programme, then there is a decision point for individual doctors as to whether they go on to further training. For some specialties, that will involve core training and then higher specialty training. For others, the training will run through. Many doctors during the course of their training choose to take time out—they may go off for family reasons, for maternity or paternity leave, to do research for a year or to get experience in different organisations and come back. There is a wealth of different reasons why people choose to take time out. That is one of the reasons why it is hard to answer your question. I can try to get some data on that.

Richard Lyle: That is called life.

Caroline Lamb: Yes, it is. People have complex lives.

Trisha Hall: In the context of workforce planning for social work, we have known for a long time that there are huge issues in relation to mental health officers, particularly in adult care, because we have a greatly ageing population working with a greatly ageing population. The legislation on adults with incapacity, under which MHOs have to assess capacity, puts us in a difficult situation. Social workers have to do work that is the equivalent of a master's degree to become an MHO, and they have to be released from their substantive tasks in order to do that. Those people often work in children and families teams and other busy teams, and someone being released from that workload will have an impact on that work and on their team. Although the chief social work adviser to the Government has commissioned reports on that and the problem has been known for some time, it is difficult to say to local authorities that they must do something about it, because local authorities make their own decisions.

One or two years ago, NHS Highland ended up supporting five social care workers to undertake their social work degrees. There are different models that can be used to address that problem, some of which are quite imaginative and can work well, but that requires some courage.

Miles Briggs: I wanted to pick up on the points made by Richard Lyle and Caroline Lamb. To what extent do you think that the university and college sector is not helping to address the problem, specifically given the capped number of places? Since the Scottish Parliament was reconvened, the number of Scotland-domiciled medical students has gone from about 65 per cent to around 50 per cent. To what extent do universities have to do more both to accept more students and to accept more students who are likely to stay, live and work in Scotland? What else can be, and is being, done to get people who have left Scotland to work elsewhere—perhaps Australia or New Zealand—to come back and work in our health service?

Caroline Lamb: Our universities, in respect of medicine, and our colleges, across the range of other professions, have a huge contribution to make. It is not just about where students come from but is also about the experiences that they get while they are at university. Along with the Scottish Government, NES is working closely with our universities to try to ensure that more students get an opportunity to experience remote and rural placements, for example, and placements in general practice, while they are studying. Having positive experiences in those areas is something that leads them to express an interest in continuing a career around that. That is really important.

Personally, I am absolutely committed to the widening access agenda. I have mentioned it a few times already. It is one of the ways in which we can try to ensure that we get more eminently able Scottish kids coming through to the medical schools.

Jill Vickerman: I will try to be brief. I want to pick up on Richard Lyle's suggestion to Caroline Lamb that we might consider requiring doctors to stay in the NHS in Scotland post-qualification. It is a challenging issue. Our strong view is that the most important thing to do is to make posts attractive to people so that they will come and stay in Scotland for them. That was Caroline Lamb's point. We are concerned about a direction of travel that leads to forcing people to stay in the NHS post-training. That is a short-term approach, because the impact on the doctors' morale would be extremely negative and it would not send a positive message to those doctors we are trying to attract to Scotland. We would not be at all confident that, after five years, you would have someone who was committed to the NHS.

However, members may be aware of a scheme that was just announced in NHS Wales, under which GPs are being offered a £20,000 golden handcuff to stay in the NHS for a year. We are interested to see what the impact of that is and what the longer-term benefit is to the NHS. That is something for us to watch carefully.

I also want to pick up Miles Briggs's point about shifting the balance in the number of Scotland-domiciled medical students. There is a general consensus that that would have a positive impact

on the number of medical students who would want to continue to train and stay in Scotland. The concern that I am hearing about that kind of change is about the profile of Scottish universities and the sense that they need to have the freedom to select and choose students across all their specialties who will allow them to punch above their weight on the worldwide stage, as they currently do. That is what makes Scottish higher education so attractive for others. We need to be careful how we play with some of the variables.

Miles Briggs: To what extent is the way in which we fund our universities in Scotland having an impact? A Chinese student coming to study medicine in Scotland at the University of Edinburgh would pay about £30,000. To what extent are decisions being taken about where the students are coming from on the basis of how the university is financed rather than where they are going to work when they leave university, particularly in respect of medicine?

Jill Vickerman: Again, there are a number of different, conflicting variables involved in such decisions in the universities. Yes, there is a financial incentive to attract people from outside the European Union, but there is also the other impact that changing that balance would have on how the university is perceived on the worldwide stage.

Richard Lyle: I do not want to hamstring anyone or tie them down, but if a country gives you an opportunity to train to be something, you should at least give something back to that country. With the greatest respect, if you do not like it, then go and train somewhere else.

The Convener: I have an observation on that. When the teaching profession brought in a one-year probation scheme after training, that had a positive impact on morale, because people had a job for a year before they had to move on. I have some sympathy with that point.

Adam Longhorn: I have a couple of points in answer to Miles Briggs's questions. The evidence that we presented today was compiled from 12 different allied health professions and from allied health profession directors. Some of the feedback was that there are very few training places for some professions and so some students come from the rest of the UK and then return home after they are qualified. There are often no vacancies when people finish their training, which is a difficult point to remedy.

Funding for placements outside the central belt—the problems for us outside the central belt are not just in remote and rural areas—is very important, because such placements can cost individual students up to £600 a time. This may be the antithesis of Richard Lyle's point, but for professionals coming to the UK for the first time, who need to register with the Health and Care Professional Council, the process can take 16 weeks and can cost an individual £500. There needs to be some support for bringing people in and making it easier for them to come and take up posts.

Maree Todd: I wanted to ask about agenda for change and the consultant contract. Adam Longhorn mentioned that there might be some impact on the allied health professions workforce from the downgrading of bands. The written evidence also mentioned that the perception that the agenda for change banding in Scotland was less generous than that for the rest of the UK might be a reason for drift to the rest of the UK. As someone who worked in the health service and was well aware that, in Scotland, we implemented the pay recommendations of agenda for change so that our bands get paid higher than the rest of the UK, I am interested to know whether there is any evidence for that suggestion and whether there is anything that can be done about it.

My second question is to the medics in the room. I heard from the Royal College of Physicians in particular about the concern about the consultant contract and the 9:1 ratio. Are there contractual issues that need to be tackled to address workforce retention?

10:45

Adam Longhorn: I am afraid that I will have to hold my hand up and say that I cannot answer that question in depth but I will submit some supplementary evidence for you to answer it directly. I apologise.

The Convener: No problem. Would anybody else like to come in on that?

Jill Vickerman: I will pick up your question about the consultant contract, Maree. As you say, there is a continuing issue that relates to what is described as the 9:1 element of the consultant contract. For those of you who are not familiar with that terminology, I will explain.

The current consultant contract is nationally agreed and allows for, usually, 10 sessions a week of four hours each for each consultant. The expected balance between the amount of face time that the consultant has with patients and the amount of time that they have to contribute to the wider development of the NHS—teaching the up-and-coming medical students and trainees and contributing to their own professional development—is supposed to be two and a half sessions for that wider, qualitative contribution and seven and a half for direct patient contact. The intention in the contract is that that should be the starting point of discussion and the expected

balance between the different types of activity. In certain circumstances, however, and when agreed between the consultant and their employer, it should be able to vary in either direction.

The reality is that we have found that consultants are being pushed to spend an awful lot more face time with patients to try to address the challenge of increasing demand and that they have less and less time to contribute in those various other ways. That has impacts on the training capacity that we have in Scotland and our ability to innovate and change, which—as we discussed earlier—is vital at this time. On top of that, it has a negative impact on the morale of the consultants who are currently in post and on the attractiveness of consultant posts in Scotland. One of the reasons that doctors outside Scotland most often cite for not wanting to come and take up a consultant post here is the sense that Scotland is a 9:1 contract country. There is a real opportunity for us to tackle that and it does not require changes to contracts; it requires adherence to the current contract.

Dave Watson: The trade unions do not want to give the impression that they think that agenda for change has not been implemented properly in Scotland or that it has been done better in England—for a range of reasons, it is pretty chaotic down there—but that is not to say that there are no issues. In particular, one of the issues with agenda for change is the long scales. There is some work being done on that. If that is not tackled soon, there will undoubtedly be equal pay challenges when people find that they are sitting for a long time on scales that do not necessarily reflect their duties, responsibilities or qualifications. There is some work to be done on agenda for change but, in general, we are reasonably happy.

We should also remember that health boards have some control over banding under agenda for change because they control job descriptions. Certainly, I have seen cases in which the job descriptions have been badly drafted and, therefore, probably not properly banded or approached differently from what might apply elsewhere in the UK. We should also remember that, if there are real problems, health boards have the option of recruitment and retention premia under the agreement. Agenda for change is sometimes described as being too rigid. Actually, it is quite a flexible agreement but it depends on all the players to be flexible in using it.

Colin Smyth (South Scotland) (Lab): I will follow up the point that Jill Vickerman made on the erosion of supporting professional activities—SPA—hours. Has any work been done to quantify the extent of that problem and how many consultants would be needed in order to achieve the figure of two and a half sessions for SPAs?

Jill Vickerman: Quite a bit of work has been done on the balance of 9:1 versus 8:2 or 7.5:2.5 in the new contracts that are set up for people who are being taken into post, but there is a continuing focus on 9:1 contracts, which is really worrying. I have not seen any analysis of the broader question of what would be the total capacity required to free a proportion of consultants who are working on 9:1 to shift back to the 7.5:2.5 arrangement. It is clear that a significant piece of work will be required to understand what would be needed to allow and support not only new consultants coming into post but those who are already in post to do that.

Adam Longhorn: I thank Colin Smyth for that point and repeat my earlier point about looking forward. We have examples of consultant occupational therapists leading stroke clinics. In one particularly exciting example, a project was unable to recruit a medical consultant to a rehabilitation clinic; it recruited an occupational therapist and the results of the project kept improving. That shows that there are alternatives to the traditional models that can be used.

The Convener: I will raise some associated issues. Agenda for change deals with the terms and conditions of NHS staff. We are discussing the issue in negative terms in relation to workforce planning and the gaps that exist but, for some people, it is positive because it appears to them that there is a Klondyke going on for people who run agencies and a small group of senior consultants who earn three times the salary of the First Minister. It looks as though shareholders in nursing agencies are living it up large at the moment because of that.

The Audit Scotland report says that the average cost of a salaried nurse is £36,000 whole-time equivalent but the cost of an agency nurse is £84,000. I do not know whether anybody has this information, but how much of that is clear profit for the agency? Perhaps the RCN can help on that. Do you know, Sian?

Sian Kiely: I do not have figures for the split between what the agency receives and what the nurse receives from what is paid in agency fees. However, the volume of cost and the increasing amount that is being spent on agency and locum workers across the health and social care services is a matter of concern. Particularly in the past year, there has been a dramatic increase of nearly 47 per cent in the cost of nursing within the NHS only.

It is important that there be increased focus on agency and locum workers and I know that work is being done on that. It is a valid point to consider

because the amount that is being spent on them is a real indicator of pressure. The Royal College of Nursing would make the point that, if there is a demand for those nursing roles, the focus should be on considering employed posts rather than continuing to use agency cover.

The Convener: The Audit Scotland report suggests that agency cover is being used for long-term, rather than short-term, vacancy cover. That is a concern. There was a 4 per cent increase in internal bank nursing and midwifery staff, a 47 per cent increase in agency nursing and midwifery staff and a 33 per cent increase in medical locums. Those are all big figures that appear to be continually going in that direction. It might be that we do not have the right people around the table to get into the guts of the issue. The committee might have to think a bit about how much of that is pure profiteering and how much of it is legitimate cost.

Clare Haughey: A number of the written and oral submissions to the committee have raised issues about recruiting staff from overseas. Health and social care providers use staff from the EU and outwith the EU and some rely on them more heavily than others. Can the panel members comment on how the changes to immigration by the UK Government have impacted on recruitment from overseas and also whether they have seen an effect of the changes to the post-study work visa?

Caroline Lamb: When I spoke earlier I raised the point that the move away from permit-free training in the UK, which happened some years ago, has had an effect on recruitment into medical training posts. I cannot comment on the post-study visa effect, but I can say that about 20 per cent of the medical undergraduate population in Scotland is from either Europe or overseas. It is probably a concern to us all what might happen to that population post-Brexit.

Dave Watson: The honest answer is that the data is very poor indeed. We do not know the precise answer. Someone asked a similar question the last time that I gave evidence and I think that I said that the day after Brexit I was busily trying to find some data, but I did not succeed. We have been doing some survey work with our members and what is clear from that is that a certain proportion of them—predominantly EU nationals, rather than those who come from outwith the EU—have considered leaving because of the uncertainty and the lack of a guarantee about what will happen post-Brexit. That is why it is our number 1 ask of the UK Government to provide clarity and certainty on that. We probably have about 6,000 members in Scotland in that situation. They are concerned for their future and some of them are considering returning.

The sector where the issue is most prevalent is in the private residential sector—we have received the bulk of responses from there. The members concerned range from fully qualified nurses to other social care staff. There are quite large chunks of affected staff in the home care sector. That is not hard data. There is plenty of anecdotal stuff and survey response work, but we do not have the hard data.

What is clear is that those are the sectors where we are struggling to recruit and retain at present, so we can be pretty sure, given the demands on the sector in the future, that we will have to address the issue. Plugging the gap without overseas or EU nationals will be beyond challenging.

The Convener: Candy Millard, does what Dave Watson said reflect the experience of your organisation in relation to social care staff?

Candy Millard: We do not employ anyone in the health and social care partnership—they are employed by the NHS, the council or third sector providers. We benefit from being in the central belt, so we probably retain people for longer because of our area. We struggle the most with recruiting staff in specialist roles—for example, it has been difficult to recruit a consultant for our child and adolescent mental health team. Our providers experience similar problems to those that Dave Watson was discussing in relation to recruitment and retention of social care staff.

Clare Haughey: I was specifically trying to find out about non-EU nationals. Constituents have raised the issue with me, because it is particularly difficult for them and people they know to get visas to come to work in health and social care in the UK.

I will move on to EU nationals. How do panel members feel about the impact that Brexit will have on recruitment and retention in the UK?

Sian Kiely: Thank you for that question. The UK's exit will have a profound effect on nursing across the UK and in Scotland. The Royal College of Nursing published "Unheeded warnings: health care in crisis—The UK nursing labour market review 2016", which contains data and information on both non-EU and EU nationals working in nursing across the UK. Looking at what is happening in both health and social care employers—certainly in the care home sector—the potential impact of the UK's exit from the EU is an issue that is coming to prominence. That report contains some detailed information.

11:00

Clare Haughey: I have a brief supplementary question on that. What are the national

organisations doing to lobby the UK Government about the issue?

Dave Watson: We have lobbied. We have written a number of briefings for the UK Government that also support the Scottish Government's initiatives in this area. Our number 1 ask at the moment is for the Government to give a guarantee to EU nationals who are currently living in Scotland—and more broadly, in the UK—that they will have the right to stay post-Brexit. That is essential, because the longer that drags out, the more uncertainty there is and the more likely it is that we will lose those key workers in some sectors. There are big issues in not just health and social care, but a number of other areas where we represent staff, such as construction.

We are lobbying loud and hard on that issue. We welcome the support that we have had in Scotland. Opinion polls have been extremely positive on that. The public gets that point. Even among those who voted to leave, a clear majority believe that people who are currently working in Scotland should have the right to stay.

Sian Kiely: I concur with those points. Across the UK, the RCN has been focusing on the potential impact of Brexit. We have made the point at UK Government level about developing a coherent workforce strategy that preserves the rights of EU nationals currently working in health and social care, as well as making sure that it is very clear what the huge impact of Brexit could be. As a UK organisation we are concentrating on those issues.

Jill Vickerman: Our position is very similar to that of others. The British Medical Association has been lobbying hard, at both the UK and Scottish levels, on the point about providing reassurance and removing uncertainty about the future for overseas employees who are currently employed in Scotland. We are hearing slightly different perspectives from Scotland and the rest of the UK because of the different messaging about the position in Scotland. That is also creating some confusion.

In our last few meetings with the Academy of Medical Royal Colleges, there has been an increasing focus on the issue and trying to get an understanding of the scale of the potential problem—it is now part of our regular agenda. The medical profession is as least as reliant on overseas staff as any of the other health and social care professions. The challenge is not just about retaining the staff that we already have and rely on so much to deliver the NHS in Scotland. It is also that we expect that in the very near future—the next months and years—there will be people thinking about coming to Scotland to take up a number of the vacancies that we are so desperate to fill. They might look at the situation in Scotland and the UK and make a different decision. That is an immediate and urgent problem. We need reassurances from Government about that and we regularly make that point.

We will start to see the impact immediately in terms of the types of applications that we get for posts, as well on the number of applications for places at university and training posts, as we discussed earlier.

The Convener: I will bring in Miles Briggs.

Miles Briggs: I do not actually have a point.

The Convener: You were indicating that you wanted to raise something. Do you want to come in later on?

Miles Briggs: I have already raised the points that I wanted to raise.

The Convener: That is fine.

Tom Arthur: I have a final question. The UK Government has characterised EU nationals as "a bargaining chip". Given that there has been no clarity from the UK Government and given that it voted against a motion in the House of Commons to reassure EU nationals, what will the impact be if such people are denied the right to remain in the UK?

Dave Watson: I can be clear about particular sectors. In the residential care sector, the absence of overseas nurses and other care workers who are employed in that sector would be devastating. The numbers from the cases that we handle in that sector suggest that the majority of staff are overseas nurses or EU nationals. If they went, that sector would have problems. I am sure that Donald Macaskill would be happy to clarify that from the employers' perspective, but that is our impression.

Increasingly, we are seeing issues in the home care sector. For particular groups of staff who responded to our survey, the numbers are somewhat larger than I expected. There will be an impact there. We are talking about care professionals, whom we would expect to have a certain culture and to behave in certain ways, but the problem is that, when they are treated in a way that is somewhat subhuman by being described as "a bargaining chip", they feel that they are not wanted here. There are other countries in Europe that have exactly the same demographic challenges as we have in Scotland and, if those staff feel that they are not wanted here, they will go elsewhere, believe you me. That would have a devastating impact on health and social care in Scotland.

Jill Vickerman: I hope that my previous answer reinforced what a devastating impact there would be on our medical workforce. One EU source of medics that people sometimes do not think about is southern Ireland, where a significant number of our doctors are trained. The potential impact of reducing the flow from that source and causing uncertainty is unmeasurable at the moment. We all see a hugely worrying potential impact on the numbers of people in post, the potential flow into the country and the morale of all the other workers around them.

Trisha Hall: I concur. The British Association of Social Workers has already made representations to Westminster on the issue. If a lot of social care professionals left, that would have a huge impact on social work. On the issue of being "a bargaining chip", I have lived in Scotland for about 30 years as a Dutch citizen. I feel personally quite strongly about the issues—I need to be careful not to get too involved.

Richard Lyle: I turn to financial matters. When people are 20, they do not worry about having a pension, but when they get to 50 or nearly 60, they start to think about it. Have changes in the pension arrangements and tax incentives for doctors in that age range been a factor in doctors stopping working or cutting their hours?

The Convener: That could apply to health professionals generally.

Richard Lyle: I ask whether the changes have been a factor for everyone, then. I do not know whether I have the figures right, but I think that a doctor's pension pot can be only up to £1.5 million; if they work on, they cannot make more contributions. I may be wrong—correct me if I am.

Jill Vickerman: The answer is straightforward: of course the situation is having an impact on doctors' decisions about whether to continue working and in what capacity. The reality is that it is affecting the availability of our most experienced doctors to work in longer-term careers. Across all branches of practice, there are doctors under significant pressure who are stressed or who see an increasing demand on them. Often, the advice on their financial positions is that it is not the best decision for them to keep working.

Sian Kiely: The impact of pension considerations is a really important issue to discuss. In certain areas of nursing, where large groups of nursing staff are approaching retirement, the issue of potentially working many more years—in a physically demanding job—is prompting nurses to consider what their options are.

That scenario means that we have concerns that more nursing staff in some areas will choose to retire, such as those in community nursing and mental health nursing. Many mental health nurses have the option to retire at the age of 55.

The Convener: One thing that has been raised with me is ambulance staff working much longer—they have to carry people up and down tenement blocks and the like.

Dave Watson: The tax changes in relation to the annual lifetime allowances are capturing a lot of staff quite far down. The issue is being discussed with the Scottish Government, which will consult on whether to take up some of the UK Government's changes in England. That could have an impact.

In fairness, the policy aim was to capture some highly paid staff and some private sector practices that are, essentially, tax avoidance. The change was not made for bad reasons. Unfortunately, as is often the case, there were unexpected consequences.

The point about retirement age is important. We have recently had the Cridland review at the UK level, which looked at the normal retirement age and particularly the state pension age. Cridland identified that, because different jobs make different demands on people, it can be difficult to say whether having a single retirement age for everyone is the right approach.

In a lot of the areas that we have discussed today—for example, in social care, where all the people are covered by the local government pension scheme—the average pension is less than £3,000 a year, and I have to say that people are not looking to grab that early. I am the trade union side secretary of the local government pension scheme. Ten years ago, people would ask me, "How do I get early retirement, Dave?" Today, I get far more questions about what happens when someone carries on after normal retirement age. That is largely to do with the adequacy of pension provision, particularly for women who might have had career breaks but also for low-paid men.

Pensions are an important aspect. We should also emphasise that a good pension scheme is an important recruitment and retention tool that we should defend keenly.

The Convener: We are almost at the end of this evidence-taking session. Adam Longhorn may have the final word.

Adam Longhorn: I support everyone else's comments about the pension age and I thank the convener for his point about ambulance staff and the pension age. The issue has been considered at Westminster, and it was felt that it was okay for ambulance staff to keep working until they are 67 because they are not in an at-risk profession. We thank you for your interest and we would welcome

any thoughts from the Scottish Government on the issue.

The Convener: I thank everyone for their evidence. Some people said that they would supply the committee with further information, which they can send to the clerks by email, in a letter or however they wish to do it.

11:12

Meeting suspended.

11:18

On resuming—

The Convener: Our second round-table discussion will focus on rural recruitment and retention. I welcome everyone to the committee.

I am Neil Findlay, the committee's convener and a Labour MSP for Lothian. I invite everyone to introduce themselves. As I said to the previous panel, we just need a brief introduction—no biographies, please.

Gill McVicar (NHS Highland): I am the director of operations in NHS Highland.

Clare Haughey: I am the deputy convener and the MSP for Rutherglen.

Tom Arthur: I am the MSP for Renfrewshire South.

Ron Culley (Western Isles Health and Social Care Partnership): I am the chief officer, health and social care, in the Western Isles health and social care partnership.

Miles Briggs: I am an MSP for Lothian.

Jim Cannon (North of Scotland Planning Group): I am the director of regional planning for the north of Scotland planning group.

Alex Cole-Hamilton: I am the Liberal Democrat health spokesperson and the MSP for Edinburgh Western.

David Hogg (Royal College of General Practitioners): I am a rural GP on the Isle of Arran and I am here on behalf of the Royal College of General Practitioners.

Alison Johnstone: I am an MSP for Lothian.

Dr Donald Macaskill (Scottish Care): I am the chief executive of Scottish Care.

Richard Lyle: I am the MSP for Uddingston and Bellshill.

Gillian Smith (Royal College of Midwives Scotland): I am the director of the Royal College of Midwives Scotland.

Maree Todd: I am an MSP for the Highlands and Islands and I am a pharmacist.

Stuart Fergusson (Royal College of Physicians and Surgeons of Glasgow): I am a general surgical trainee and I am currently at the Royal College of Physicians and Surgeons of Glasgow.

Colin Smyth: I am an MSP for South Scotland.

Ivan McKee: I am the MSP for Glasgow Provan.

Bill S McKerrow (Scottish School of Rural Health and Wellbeing): I am an associate postgraduate dean with NES in the north, and I am representing the Scottish school of rural health and wellbeing.

The Convener: Thank you very much, everyone. We have just over an hour for the session, so brevity would be appreciated. Would Maree Todd like to begin?

Maree Todd: Thanks, convener—where to start? One thing that struck me when I read the submissions was the change that has happened in midwifery training. Almost all the submissions said that one thing that enabled them to recruit to rural areas was people's experience of working in rural areas during training. It therefore struck me as an odd decision to stop training midwives in the Highlands and Islands. Can anyone give me a bit of background to how that decision was made and when it might be remedied?

Gillian Smith: I have lived through quite a lot of the history of this. The decision was made because of the change, some time ago, from double duties to single duties, which came about because of a wish to enable midwives to concentrate on the care that they need to give women. Previously, if someone was looking after a person who was terminally ill with cancer and a woman who needed an antenatal visit, their priority would perhaps go towards the nursing agenda and they would end up not providing the care that was needed under the midwifery agenda. The double-duties approach was always helpful in the Highlands and Islands, but there was a difficulty in replacing midwives when they went on leave and so on.

I think that you are alluding to the change from six universities to three. The University of Stirling no longer trains midwives at its campus in Inverness, and the University of Dundee and Glasgow Caledonian University have also left us. Robert Gordon University, Edinburgh Napier University and the University of the West of Scotland still train midwives—they operate a hub-and-spoke model.

You ask a good question, because how people appreciate the place where they do their clinical

placement has an impact later. Robert Gordon University has been covering the Highlands and Islands. Recently, it placed two student midwives in the Western Isles—I think that one of them originally came from there. The students enjoyed their placements so much that, in October, they will take up two positions in the area.

That is an excellent example of why, if we are going to operate a hub-and-spoke model, we have to give people the opportunity to see what it is like to work in a remote and rural area. Working in such areas is quite different. The timing of decisions has to be different because, if things go wrong in that environment, we need to be able to transfer people quickly. Those decisions are extremely important.

Another aspect is the fact that we went from having 220 midwives in training to 100, which was a steep decline. I heard Sian Kiely talking about the fact that, now, three years later, we are getting significantly less than we got before. One reason for the change was oversupply. Routinely, even before the current Administration, which I think means going back six or seven years, ministers got letters from people's parents, grandparents, aunties and uncles that asked, "How can you train people and then not give them a post?" That is when the one-year job guarantee started in midwifery—it later carried over into nursing. However, we are no longer in such a situation. Now, there is difficulty in recruiting to midwifery posts.

It would be easy if we could say that the issue was significant only in the Highlands and Islands, but we should think about how big the central belt is. We know that we are having difficulty in recruiting to the community maternity units in Inverclyde and the Vale of Leven. We recently had to close the unit in Montrose because it did not have enough staff. I think that most people know about the situation in Aberdeen, which has had to manage its services while being 26 full-time-equivalent staff members down. That puts stress on the people who are left behind in the service.

How far is the central belt from such a situation? Lothian and Glasgow do not appear to have a problem, but the Clyde part of NHS Greater Glasgow and Clyde certainly has a problem. I worry about the future of services in more remote and rural areas.

The Convener: What was reduced from 200 to 100?

Gillian Smith: The figure went down from 220 to 100.

The Convener: Was that 220 training places a year across Scotland?

Gillian Smith: Yes.

The Convener: Over what period was the reduction made?

Gillian Smith: I think that it was done quite quickly—over two years at the most. It was probably done in the space of a year because of the oversupply that we had.

The Convener: When was that, approximately?

Gillian Smith: I will try to remember exactly when it was—I think that it was around 2012 or 2013. When I was getting off a train from Dundee, I was told that the number was going to drop.

Maree Todd: Does Gill McVicar want to answer?

Gill McVicar: There is little to add, as Gillian Smith's answer was comprehensive. We agree that people who train in remote and rural areas are more likely to come back. Operationally, we would welcome clinical placements for students of all disciplines.

The Convener: Do students get additional support to take up those placements? For example, if an Edinburgh student wanted to take up a rural placement in Dumfries, the Highlands or wherever, would they get support for their accommodation and that kind of thing?

Gillian Smith: Students would get support, but there is sometimes difficulty in finding accommodation for them, and it is sometimes even more expensive to provide that support in the central region than it is in remote and rural areas. During the summer holidays, when there are a lot of tourists in the Highlands and Islands, there is no doubt that it can be difficult to find accommodation.

Alex Cole-Hamilton: The previous panel told us of a commensurate drop in the number of nursing places at about the time that Gillian Smith mentioned or a couple of years before that, which strikes me as a myopic way to save money. In various areas of the health sector, we are storing up problems for the future by exposing ourselves to the prospect of a diminishing workforce, which is what you are describing.

Gillian Smith: There was a bit of fear about the oversupply, because we had no jobs for newly qualified midwives. At that point, it was almost disingenuous to train them without having employment for them. However, over the past few years, the numbers have built up again. We took in 183 students last year, and the group that is working with the Scottish Government is waiting to see the number for this year.

We did not have a robust workforce planning tool for midwives and I am still not convinced that we have one. I reflected on that last week at the Scottish partnership forum. The NHS is running a

third test of its workforce planning tool for midwives. If it is having a third run to test the tool, it cannot tell me that the tool is robust. I have concerns about that.

Alex Cole-Hamilton: I think that Audit Scotland would agree with you, given the report that it published last week. We have a workforce planning cycle of five years, and the situation is an indictment of the Government's approach to workforce planning across the health sector. What you are telling us is troubling.

Ron Culley: I will take a more general approach, because what is true in midwifery is also true in other areas. The evidence that we have submitted on the recruit and retain project is illuminating in that respect. In particular, having experience in a remote and rural area as part of their on-going professional development or qualification—whether that is in medicine, midwifery, dentistry or physiotherapy—has a positive impact on the degree to which someone is prepared to take on a bigger commitment to live and work in such an area. That cannot be underlined enough. It is hugely important, and anything that we can do to support that should be done.

Ivan McKee: I will explore issues of workforce planning. From the outside, it does not look too difficult. There are a number of variables, and assumptions have to be made about what will happen, but developments can be factored into the model as you go.

The scenario that has been described—of dramatic oversupply and then dramatic undersupply—should not happen if workforce planning is done correctly. What is in place and how effective is it? The task comes down to figuring out what the demand will be, how many people we will need and how we will supply them. To what extent are such processes in place?

11:30

The Convener: We have been concentrating on midwifery, but that question was more general, so I ask others to please come in on it.

Ivan McKee: Absolutely—I am asking about wider perspectives.

Gillian Smith: We are looking at what the numbers will be for next year's intake, so the question is really interesting. I was interested in what Caroline Lamb said because, for the first time, we have seen the use of the scenario planning tool that NHS Education for Scotland has been developing. It gave me a different approach to what I thought I would lobby for. Sometimes workforce planning has been done in isolation by boards, without even getting the input of the right professionals, but I am seeing a change now.

A big issue for us has been that 50 per cent of neonatal units were staffed by midwives in the past, because we were dual trained—we had done nursing and midwifery. That is no longer the case, so we are having to see that there is a balance in neonatal units.

I was interested to hear the convener talk about a 4 per cent increase in agency staff. I suggest that quite a lot of the 4 per cent are working in neonatal units. Midwifery uses bank midwives who are employed by the health boards, and there is a hidden problem that we do not see the right measure of bank staff, because the figure is not external. The staffing situation in some areas is now so difficult that even those who are in the bank are burnt out and not coming in for their extra shifts. That is difficult.

Dr Macaskill: Scottish Care's members employ about 10 per cent of nurses in Scotland. Three years ago, we had a vacancy level of about 12 per cent, and last year it was 18 per cent. Research that we will publish on 18 November will show that the vacancy level is now 28 per cent. We face a critical situation, which has a compounding effect on the whole health and social care system. If we do not recruit and retain nurses in social care, that has a profound impact. Our report will illustrate why that is the case, but one of the reasons for the situation is certainly workforce planning.

A few years ago, the 10 per cent—the contribution of social care providers—was not included in the calculations that determined the relative intake into nurse training each year. That has now been remedied and, in some parts, the reason for the shortage of nurses is that we did not train enough of them three to five years ago. With health and social care integration, we have an opportunity to develop an appropriately robust model for and method of workforce planning. There is an opportunity to evidence that through shared training and placements.

I have just experienced the first-ever placement of a physiotherapy student, who is about to finish his studies. Half his time was spent in a general hospital in Oban and the other half was spent with a care at home organisation. That had huge benefits for the patients who received support in the community. There is the potential for us to plan appropriately and to learn some of the lessons from elsewhere about how we can co-train and co-locate individuals.

The Convener: How are your members covering a 28 per cent vacancy rate?

Dr Macaskill: They are covering it by using agency staff.

The Convener: What is that costing?

Dr Macaskill: Our report will indicate that the agency costs are, on average, around £345 a night for a night shift, but that can go up to £800. Needless to say, the nurses are not going home with £800 at the end of their shift.

The exponential increase in agency use has impacted deeply on social care providers in the past 18 months to two years, and the position is getting worse. Paradoxically, I heard the other day of agencies that have ceased to trade because they could not find enough nurses.

Agencies are a manifestation of the problem. We do not have enough nurses—certainly, we do not have enough who are willing and prepared to work in social care. There are lots of reasons for that. Our report on 18 November will explore why social care nursing—particularly for older people—still remains an unattractive option.

The Convener: Is profiteering going on? I am not expressing an opinion on that; I am just asking the question.

Dr Macaskill: Do you mean profiteering by agencies?

The Convener: Yes.

Dr Macaskill: I am probably not in a position to comment on that. The agencies exist to create a business; they have seen an opportunity, which they have taken. The situation is having a profound effect on the viability and sustainability of care home providers, whether they are private, for profit or charities.

David Hogg: I go back to the idea of undergraduate involvement across all specialties. As a rural GP, I know that it makes no end of difference if someone I speak to—even if they are in a big secondary care hospital such as the Queen Elizabeth university hospital in Glasgow—has had a rural placement and knows what that is like. One of my favourite quotes is, "Knowledge without perspective is a higher form of ignorance".

A third of Scotland's population live in rural areas. An understanding of Scotland's demography is extremely important for people who are working in any sector, whether they are based in a rural area or a city. The leaders of all different professions who go into managerial positions must have that perspective as well. There is sometimes a slight leaning towards people who are city based going into those management positions more easily.

We have been concerned to notice a disconnect between strategic aspirations—particularly those of the Government—and the operational reality. One example comes from "Realistic Medicine". It is a fantastic report—a lot of clinicians across the board are reading it and think that it makes sense—but it is not matched with realistic funding, realistic management and the realistic expectations that come with that. That leads to frustration and even further disconnect.

Connectivity is the biggest issue that GPs face in pursuing the innovation that happens in general practice—particularly in rural general practice. To take on the point about disconnect, I must raise with committee members an aspect of the Highlands and Islands Enterprise roll-out of broadband connectivity, which is funded by the taxpayer. Connectivity makes the whole thing sustainable; it connects us and allows innovation to happen. Fibre is going outside Brodick and Shiskine health centres to allow us to connect with Lamlash medical centre, but one figure has particularly concerned us—despite millions of pounds of HIE funding, we have discovered that it will cost upwards of £115,000 to get three of our sites connected to Lamlash medical centre.

There is a complete disconnect in how that is happening. I get better connectivity to our Lamlash server from Tromsø, which is 500 miles north of the Arctic circle, than I do 5 miles up the road in Brodick. I do not mean to raise too much all at once on that issue, but having connectivity is very important in people's experience of rural practice. People want it.

Last night, I turned down the 82nd application for a student elective on Arran in the past year. We can take only two or three; there is no mechanism for the students to be signposted to appropriate areas that will take them. Connectivity and the disconnect between strategy and operational reality are a huge issue for us, which is causing us a lot of frustration.

Jim Cannon: In my experience, workforce planning is complex in the health service; it is not a binary question of replacing like for like when it is considered in the landscape of the constant pressure to innovate, to skill mix and to change. When the pressures are on the sustainability of services, workforce planning is not an easy job.

Ron Culley: I will build on that. We also need to reflect on the fact that workforce planning is undertaken at different levels in our system. We have talked in the main today about national workforce planning, which it is important to consider, but it also happens regionally—that is the work that James Cannon does—and locally.

One thing that integration authorities must have regard to is how we want to change our services over time to meet population need. By virtue of that, we envisage a different workforce over time, so we need to ensure that the work that is done strategically at local, regional and national levels is

being joined up, and we probably do not have that arrangement in place.

The Convener: The point that David Hogg made is important for our constituents in relation to the problems that they come to us with in the health and social care field. Is there a general feeling that there is a disconnect between the policy, strategy and rhetoric on the one hand and the material reality on the other, or is David Hogg way out there on his own?

Bill McKerrow: I agree with what has been said. The whole of healthcare planning has been bedevilled by a series of projects working in different ways and not being joined up effectively. In essence, people are discussing the same thing in different rooms but are not pooling their resources and putting their intellectual energy into moving things forward.

The Scottish school of rural health and wellbeing, which I chair, was established to fill that gap. It is a loose strategic alliance between our academic partners in Highland; it involves NES and incorporates RGU and NHS Highland health and social care services. What we have achieved and could achieve much more of is a collaborative environment in which we work together. Another series of projects will come along, and there is the Scottish rural medical collaborative, which is a follow-on to the being here project. However, those are all individual projects, and we require continuity if we are to make big gains, so I make a plea in that direction.

Miles Briggs: It was interesting to hear from David Hogg that there were 82 applicants for just two positions and that he did not know where or how to signpost people. Why have the organisations that are represented on the panel not been working on that rather than waiting for the Government to come forward and say, "This is how you should be doing it"? In any other field, people would have decided to put together a framework to achieve that.

David Hogg: We have. I used to forward applications to my colleagues in Skye and Islay, who are in the same situation. At college level, we have tried to look at how we can invest in and resource that.

The Rural GP Association of Scotland is holding its conference on Thursday and Friday this week. There is no end of enthusiasm and we are doing a lot of work to do what we have discussed. The problem that we have as GPs is that there is a day job and then there is everything else. I have taken annual leave to come here, and I was going through Docman last night. There is real pressure on us at the moment. Docman is the software where we get all the letters in from consultants and share information.

I would love to take a week or two weeks out to solve the problem, because we probably have the answers on the ground. The problem is how to get the message up to the people who will listen and be able to take action, and that ultimately requires funding and resource.

Miles Briggs: We have seen the Scottish Government put forward the £20,000 bursary. There were 100 places and I think that 37 were taken up. What should the Government be doing to support that effort?

David Hogg: It should be telling us about it. I do not mean to be too critical. There are a lot of fantastic things going on in rural practice across education in Scotland. As a GP in a rural area in Scotland, I will stand up and say that it is one of the best jobs that you can have, but it does come with its frustrations. One of those is that I can open up the BBC news website to find a report on the targeted bursary scheme and a picture of Arran. Because we have been quite vocal and have done the movies to try and attract people, although people are not coming forward, there was a picture of Arran on that BBC news article to show that people can apply for various bursaries for such places.

I emailed many different contacts to find out how we could engage, because we could do something really powerful on that, but it was very difficult to find out how to engage with the process. It is a great idea and I do not mean to be overly critical of those who take such ideas forward, but we are sitting in Arran looking at a picture of our island on an article that says that Arran is a place where people can come and take up such an initiative, and yet we have to ask how we can do that and how we can take it forward.

11:45

The Convener: Some people on annual leave go to Benidorm, but you have come to the Health and Sport Committee. That is commitment.

David Hogg: That is coming later.

Jim Cannon: On Bill McKerrow's point about connectivity, there are increasing connections between initiatives and I see a lot of streamlining in thinking and resources. The national clinical strategy gives us a platform towards which to align everything.

It is quite a positive message. We are not there yet and I recognise the disconnect but, speaking for the six north of Scotland boards that I represent, the chief executives are very keen to build any new changes and initiatives from the bottom up—from the service—rather than introducing them in a top-down, strategic way.

Clare Haughey: I would like to offer David Hogg a wee bit of reassurance that the Scottish Government is not responsible for the content of the BBC news website or the pictures that it uses.

I am a bit confused. We have heard that, to attract people to work in rural communities, we need to get them there to train, and David Hogg said that lots of people want to train in such places. Where is the disconnect? Why is that not happening?

David Hogg: There is a problem with holistic recruitment. There has been a pervasive degree of assertiveness around where people should train.

This is a slight digression, but the term "junior doctors" is incredibly misleading: we have junior doctors who are 35 to 40 years old and still in those sort of training posts. Life is complex. Often, by the time people are looking for GP placements or to be employed as a GP, they have other things in life that have to be taken into account. The committee is probably aware of confidential evidence that I have submitted of my experience of that. It is galling because it is not just my experience, but the experience of many of my colleagues.

We have to get to grips with the fact that, when people move to rural areas or are keen to contribute to those communities in an effective way, it is not all about the medicine. The medicine is the fun part, but people also have to consider their family, their spouse's employment and how they are going to live in that situation. Until we get that part right and recognise that people are investing their time and career because there are potentially a lot of positive outcomes to gain from that, we—

Clare Haughey: I understand what you are saying, but that does not connect with what you said before. If you have 82 applicants for two posts, which means that there are people who want to work in a rural or island community, what is the disconnect in getting them places to work in those communities?

David Hogg: Students will often be attracted to the medicine but then realise that there are other parts of life to be taken into account. That is why, in the "Being Rural" report by the Royal College of General Practitioners, connectivity—nothing to do with medicine—was the biggest issue.

Clare Haughey: Perhaps I am not being clear enough in my question. If people are putting their hats in the ring and saying, for example, "I want to move to Arran", they have already decided that the connectivity or the social life is fine for them. Where is the disconnect between them applying and finding them training posts in those areas?

David Hogg: It is in the mechanisms that allow that to happen. I have a friend who applied to be a rural GP and who was keen to move to Dumfries and Galloway—which is really struggling for rural GPs—because she had lots of reasons to do so. However, she gave up because the human resources process was taking too long. The relocation process was not living up to what they said it would do. That is just one example, although we know of others. It struck me that for someone who wants to move to an area that is crying out for GPs to be put off the process is wrong.

Good things are happening, such as the single performers list, which is a great innovation that should do something to help, but we need to be mindful that moving to a rural location has a whole process behind it. That human resources process was enough to put someone off making a significant career decision—that is the honest truth about what happened to my friend.

The Convener: I am keen to focus not just on GPs or any one discipline, although anything that is a general issue across the board will be pertinent to the discussion.

Ron Culley: We may be guilty of thinking of remote and rural as one thing when the reality is that it is not. Somebody who wants to move to Arran to practise as a GP might not want to move to South Uist. It depends on the individual and what motivates them to work in a particular area, and that is about more than just location: it is about professional development and the type of medicine that they can practise in that context. When we think about remote and rural, we need to be careful to remember that the situation can be very different across the big parts of Scotland that are challenged in that respect.

On an earlier point, lots of collaborative work is being done in Scotland but, at the end of the day, we still work in a competitive environment. If a GP is up for grabs and Gill McVicar and I are both interested in bringing them into our partnerships, we absolutely want to collaborate, but ultimately there is a point at which we will want to put our own interests first. There is a competitive element in the labour market that we still need to give thought to, in medicine or any other healthcare profession.

Stuart Fergusson: I have a comment on the way that aspirations towards training are not matching reality. There are probably about 20 general surgery posts across the six remote and rural hospitals, 12 of which are filled at present. Recruitment is always a problem. I have submitted evidence on a survey that I did with a colleague of the attitudes of all Scottish surgical trainees. When we asked how interested they were in training and working in a rural environment, it was striking that

80 per cent of them said that we should train people in remote and rural environments and 43 per cent said that they would personally be interested in training in such an environment. However, only two of the six remote and rural hospitals have a surgical trainee. That is absolutely a lost opportunity.

I have explored the issue a little, and it seems that additional funding would be required for those posts to be made available in rural settings, but all the evidence suggests that giving people experience of work in a rural setting is one of the most positive things that we can do if we want them eventually to work there.

Colin Smyth: Those of us who live in rural areas—in my case, it is Dumfries and Galloway—have seen centralisation of services across the public service. Whether it is the police or the health service, more and more services are being centralised as part of national strategies. How has that approach impacted on recruitment and retention in rural areas given that, because of that centralisation, individuals' experiences and career pathways in those areas are now very different from what they used to be?

Stuart Fergusson: That problem particularly affects surgeons. A lot of literature has been published about the relationship between volume and outcome, and rural surgeons often feel particularly highly scrutinised for continuing to offer a wide surgical service in their environment. However, when that is done in a sensible way with clear links to bigger centres and a sense of support from those centres, care should be delivered locally whenever possible.

Gillian Smith: I want to go back to the point about training numbers. We can send only so many midwives and nurses to a particular area for training because, under Nursing and Midwifery Council guidance, they are required to be supervised and to have what is called a sign-off mentor. Another important aspect for us is the exposure of women to too many trainees.

Centralisation has had a huge impact on midwifery and we now see midwives doing things that they did not do previously. For example, in Orkney and Shetland—and, to a lesser extent, the Western Isles, because there are some consultants there—we are now seeing midwives undertaking ventouse practitioner roles, which involve assisting with the delivery of babies with a ventouse cap. They did not do that previously. Midwives also do lots of other things in those areas, but consultant general surgeons carry out caesarean sections in Shetland. As somebody said earlier, it is about having a multidisciplinary team of health professionals and seeing who will be needed to undertake a particular role.

There are also huge cultural issues involved in transferring patients—who, for midwives, will be women—from remote and rural areas to central areas of expertise. It is about how not only the patient but the practitioner who does the transfer is received. That is something that we often need to deal with in terms of behaviours and attitudes.

Gill McVicar: I want to pick up on the wider aspects of recruitment and retention in rural areas. I chair the steering group for the being here programme, which is an action research programme looking at sustainability in remote and rural areas, and we have been working with all sorts of people and interviewing them about why they did not come to a remote and rural area or, perhaps, came and then left. We have called it the being here programme because that is what it is about: it is about being here in general. As David Hogg said, is not just about the job.

We have discovered that housing is a huge issue, even initially, as the available housing in remote and rural areas is so expensive. Holiday lets, to which Gillian Smith alluded, are a big issue for people, and so is partner employment. If someone is moving to a remote and rural area, what is there for their partner? We need to work with all our public sector partners on those issues. Education for children and transport links are also important issues.

A particular aspect that I want to impress on the committee is the goldfish bowl effect of living and working in a remote and rural area. Work-life balance is extremely important for people who might have come to live and work in an area because of the environment, outdoor pursuits and other nice opportunities that arise from living there. They need to have time for that. However, people have told us time and again that they can never be off duty because, even when they are not on duty, they are stopped in the supermarket or the post office, for example, by people who want to talk to them about their issues and even challenge them about what they are buying in terms of alcohol or whatever. That is quite amusing and I can see that people round the table are laughing, but it is a huge issue for the people concerned and for their families if they are constantly challenged in that way.

We need to find some way of addressing public expectations. Dr Finlay is not around any more in those communities. We need to help people to understand that, and that it is important for our professionals to have a good work-life balance.

The Convener: I think that a number of us round the table empathise with those in that situation.

Gill McVicar: I imagine so.

Dr Macaskill: Returning to a point that Gillian Smith made earlier, I add that we need to look at what we mean by rural and remote. Our data suggest that the Borders and South Lanarkshire are among the top four most difficult locations in Scotland to recruit a nurse in a social care setting. They are not traditionally perceived as remote or rural areas, but they nevertheless have their own particular challenges.

My second point cuts across professions. We might be able to recruit nurses at entry level, but we are beginning to face the situation that, as organisations seek to reduce costs, not least because of agency costs, and flatten their structures, opportunities to recruit people to management, supervision and mentoring roles diminish. That might be a quick way of making resource savings, but it is extremely damaging in the medium to long term. If we lose that skills base of middle management—in all professions, but particularly in nursing and social care—we will face real difficulty in getting the necessary skill set for all the advanced nursing that we want to see in the short and medium term.

12:00

The Convener: My apologies to Bill McKerrow. I should have brought you in earlier, Bill.

Bill McKerrow: That is okay.

There are a few points that I would quite like to pick up. The first is that David Hogg's great success on Arran is, I think, largely down to his very effective marketing strategy. There is something to be learned from that. David has evangelised about the joys of working on Arran, and that is infectious. We could evangelise about all sorts of areas in the Highlands—and the Islands, for that matter—to make them appear more attractive to our young doctors, nurses and midwives.

Ron Culley also made a very pertinent point: rural is not just one place. If we want to attract rural surgeons, we should perhaps consider recruitment on the basis that the recruit's end point will be where they want to be. There is no point in recruiting someone to work in remote and rural areas and training them in surgery in general if their ambition is to work in Oban and the only vacancy that arises is in Shetland or Wick. We have to think our way through that training pathway, too.

On Stuart Fergusson's point about the recruitment of young surgeons, I think that that has got to happen early. We have been somewhat thwarted by the view of colleges and the surgical hierarchy that training in remote and rural areas should take place late. The trouble with that is that, generally speaking, people have by that time established relationships and their home base in the central belt, which is where they have been trained. If we can catch people relatively early—at core training level—they are more likely to remain. We have evidence of that from Wales, where such a strategy has proven to be successful.

Maree Todd: On the issue of centralisation, I have often wondered and mulled over how much of that comes from the professions themselves. Bill McKerrow, like David Hogg, alluded to the disconnect that might exist in the professions. Some of the professional leaders are very urban based and are proposing solutions that do not fit the whole country, a third of which is, after all, rural.

I wonder about the decision—which, it seems, was taken a very long time ago—to go from dual to single qualifications. There were fantastic reasons for the move, but it had a really challenging effect on midwifery in the Highlands and Islands. How can we influence the professions? As a health professional myself, I feel that much of the drive towards centralisation is coming from the professions.

The Convener: Ron, did you want to respond to that?

Ron Culley: I was going to make a more general point, convener.

The Convener: I am happy for you to do so, but I will come back to you. David, did you want to speak on that specific point?

David Hogg: Absolutely. I just want to make the point that centralisation tends to mean having bigger organisations. With that, comes security. As for interventions, we cannot mince words—we are in a crisis. We have passed that point. Cuts are being made to services—I saw that in the letters that I went through last night—and out-patient appointments are being extended.

For people who work in centralised systems, there is security. My point is simply that rural practices are actually very fragile—as, I would say, are most GP practices. Rural practices feel very fragile, but behind every good GP is an amazing practice team. On Arran, for example, we have eight to 10 GPs working in different full-time equivalents, and we employ about 32 staff on the island. Our model is very fragile, and it does not take much to sway it. An understanding of that fragility is really important, particularly as we are in a crisis that attracts a top-down approach, with people saying, "Crumbs—let's get everything under control." We need to be very careful and realise that a lot of answers actually lie in individual practices.

There is a view, supported by the World Organization of National Colleges, Academies and

Academic Associations of General Practitioners/Family Physicians—or WONCA—that when you have seen one rural GP practice, you have seen only one. It is not that when you have seen one, you have seen them all. I reiterate the point that centralisation sometimes brings a perception or feeling of security that those of us out in the more rural areas are not feeling at all. We need to be mindful of that.

Bill McKerrow: I absolutely agree with Maree Todd. There is no doubt that there is an impression from the royal colleges—I do not mean to castigate them specifically, but it emanates from the top within the professions—that a rural practitioner, be they in general practice or in any of the other surgical or medical disciplines, is a second-class citizen.

We need to evangelise about the fact that rural practice is not just about doctoring. It goes much wider than that; it is about community resilience, community support and the provision of much more than day-to-day prescriptions or surgery. That is what we need to get over to our young colleagues, because they will not do that sort of thing if they have already entrenched their career aspirations within the teaching hospital in which they learned their craft. We need to pick them up earlier and enthuse them about that.

Alison Johnstone: I thank everyone for their input. We are learning a lot today about the impact of centralisation—and not just of services. For example, David Hogg found out what was happening on Arran by looking at the BBC website. There is a marked need to improve dialogue.

My question is for Stuart Fergusson, who touched on the subject of volume to outcome. Kate Forbes hosted an event that, unfortunately, I was able to attend only at the very end, but at which there was, I think, some myth busting going on. We are told that if you want security in surgery, you should go to the one person who carries out that particular procedure time after time. I would like a bit more information on that.

Secondly, what development opportunities are there for those in rural areas who seek further specialisation but want to maintain a generalist skill set?

Stuart Fergusson: Those are great questions. There is definitely a clear relationship between volume and outcome in very risky cancer surgery, such as surgery of the gullet. It is clear that, with such risky procedures, a patient should go to someone who does a lot of them.

The majority of general surgery does not have that important volume-to-outcome relationship. Having researched emergency abdominal surgery and compared rural centres with urban centres, I think that, if anything, performance is better in rural hospitals. That is partly because the riskiest cases are transferred out but, nevertheless, the evidence is that those hospitals do a good job. From my point of view, therefore, there is not a big concern about volume to outcome.

As for the issue of maintaining skills while training for that environment, a rural surgical fellowship is offered to people around the end of their surgical training. It has been advertised less than once a year over the past while, but at times there has been the capacity to train two surgeons as generalists. Perhaps that rural surgical fellowship needs to be better utilised. In one model for maintaining skills that is being developed, surgeons from rural hospitals do some operations in a bigger centre for a week every so often. That works very well mutually.

Alison Johnstone: It sounds as if we need to be better advocates for rural surgical fellowships and what can be achieved in the rural setting.

Stuart Fergusson: Yes. The rural surgical fellowship is definitely important. We also need to finance more posts for early-career surgeons in rural hospitals.

The Convener: Your point about people keeping up their skills and indeed the whole argument about whether we need people doing repeat operations are significant in this morning's discussion. The committee might need to come back to that, as it flies in the face of many of the arguments that have been made for centralising services in Scotland.

Ron Culley: I want to come back to Gill McVicar's comments, which I whole-heartedly endorse and which get to the crux of the issues around recruitment and retention in rural areas.

The question is what we do about it and what our future strategies might be. In that respect, I want to mention a few things. It is important to address recruitment and retention by growing our own and using the latent workforce within our rural communities. That can happen in different ways, including through certain initiatives that we are looking at for vocational qualifications for school leavers looking for a career in social care. We have talked a lot about medicine today; that is important, but those other professions are hugely important, too, and some of them face just as much of a challenge with recruitment and retention.

We have been working with the universities to change the direction or interpretation of the reach programme for medicine. I am a huge fan of the widening participation agenda, having done work on that in a previous role, and our medical director and I have been working with Glasgow university on thinking about the reach programme, which

provides additional opportunities for pupils looking to enter a career in medicine to go through a programme, run by Glasgow university, that helps them access medical school more readily. We have now focused that programme on remote and rural schools. More of that kind of work would be good and the more the committee can do to support it, the better.

In addition to growing our own, we also need to think about the labour market in health and social care and how we engage with that. I have already mentioned the competitive element in that market. We have to connect with that reality.

I heard the committee talking earlier on about Brexit and the international element. We need to be honest and open about how we tackle that. Of the 13 consultants working in the Western Isles hospital, only one is Scottish. We have an international workforce; that will continue to be the case, and we will continue to need to draw down on that. We are actively recruiting from Spain just now and there are questions about whether that can continue. Again, the more the committee can do to raise that issue in a political context, the better.

There is also the question of how economic incentives play out in the labour market and what we can do around that. There has been an opportunity for health boards to pay an additional amount of money—up to 20 per cent—to consultants, but the problem is that no health board wants to do that. As soon as one does it, everyone will follow, and that will just raise the total cost. However, there might be an opportunity to think about allowing that measure specifically for rural areas and perhaps connecting with those areas more generally.

Finally, on the point about pathways through graduate training that the committee engaged with earlier, a conversation could usefully be had about the degree to which we allow a free market versus a planned economy. If we invest in a person's education, does that person then have an obligation to pay back to the society that funded that education? We have to have that conversation and open up that issue, particularly in respect of bonding and whether that is a viable opportunity. The reality is that for professions such as medicine, there is huge demand in schools and a huge appetite among school pupils to become physicians, so let us have a debate about whether that should be something that we take on.

The Convener: I have a list of people who want to come in on the discussion, but we are running short of time. I will bring Richard Lyle in on that particular point.

Richard Lyle: Ron Culley said it: the issue is the higher cost of living. London has its weighting allowance, and we have the Scottish distant islands allowance, which, at £947, works out at less than £20 a week. My son stays in Aboyne, where the cost of housing is high. My point—and this relates to the point that David Hogg made earlier—is that we used to have houses for policemen, for example. If you have to bring your family, moving can be a horrible experience, with trying to get vans and all those different things. Should boards look at putting together a package to bring people into their rural area, and should we consider having a rural weighting allowance?

12:15

Gill McVicar: Yes. This is about not only centralisation but superspecialism in all careers. We have moved away from people being specialists. We should celebrate rural generalists as experts, because, whatever their background, they are specialists in remote and rural care.

Stuart Fergusson referred to rotation. People working in remote and rural areas are being encouraged to rotate to busier areas so that they feel better connected, and that is an important support. Professional isolation is a huge issue in remote and rural areas. We also have to be open to offering more flexible career choices or portfolio careers—for example, working part time in practice or working in education and research. We recently appointed people to work in a model similar to the oil-rig model; in those cases, they want to work in a remote and rural practice, but their families do not want to move, and we are facilitating things by having them work two out of four weeks. We will have to be as open as we can to that kind of opportunity.

As for the point about people wanting to come and train, one of the challenges with regard to the 82 applicants to whom David Hogg referred is the capacity to train. We cannot just put those people into a practice; they need to be trained, and that takes a significant amount of time. We need to recognise that that can be a challenge for practices and, indeed, wider professional groups, and that might be one of the reasons why we cannot find 82 placements for those applicants.

The Convener: We have about 15 minutes left. People have mentioned aspects of the issue of financial incentives and packages, which Richard Lyle mentioned, but can you have a further think about that? Can you give examples of current good practice? You can throw those into the discussion, but please be brief, as we have only a short time left.

Colin Smyth: An issue that Gill McVicar touched on is a massive one for the south of Scotland. I am interested to know how widespread it is across the country. It does not matter how

many packages we put in place for individuals whom we might target for consultant vacancies or whatever if there are no opportunities for their partners or families in the area: there is no way that they are going to move to the area if that is the case. The wider issue of partners having no job opportunities in the private or the public sector is one of the biggest barriers to bringing people to the south of Scotland. How widespread is that problem in rural areas? Do professionals experience it in other rural areas?

Ron Culley: Absolutely.

Gill McVicar: Yes.

Bill McKerrow: That is one of the issues that we have been talking about. Gill McVicar is a fantastic advocate for new things and has been pivotal in promoting the idea that we should have a relocation officer who finds employment opportunities for others who might be considering moving to a rural area.

On Stuart Fergusson's point about rural surgical fellowships, we have tried that a number of times but have succeeded in training only one individual who ended up working in a rural general hospital—that was in Fort William. We have trained others who then elected to go to bigger hospitals, such as Raigmore or Elgin. We have found it difficult to achieve what we want from that initiative. I am not saying that it should not be part of the blend, but it is a difficult issue.

Among the people who tend to apply for those posts are overseas doctors who have been highly specialised in their field overseas—for example, in vascular surgery or cardiothoracic surgery—so they are not really fitted for work in a rural area where they would have to do orthopaedics, manage sick children and do a bit of ear, nose and throat work, a bit of ophthalmology and perhaps a bit of emergency gynaecology. There are therefore real challenges in using that model.

I want to float an idea for the sake of having it on the table: perhaps we need to look at a different model of staffing smaller hospitals, such as the one that has been implemented by NHS Highland for Caithness. There, the elective surgical and medical services are provided by a specialist from Raigmore and the emergency services are provided by well-trained rural practitioners who have the basic skills to resuscitate people and to manage acute situations, which could be anything from a road traffic accident to a mental health emergency, and which could involve anything from gynaecology to an abdominal surgical catastrophe. They can stabilise the individual and arrange for them to be transferred.

That model works well for Broadford hospital as well, where the population is small. It is an expensive model, but recruitment and retention has not been a problem in that area, because people get good training, they have an interesting and varied job, and they get plenty of time off to enjoy the pleasures of being in Skye. That is an idea to have on the table.

Clare Haughey: An issue that I asked the previous panel about, which we have touched on, is recruiting overseas staff. Ron Culley has alluded to it in relation to the consultants in the Western Isles. Have the changes in work visas had an impact on your ability to recruit overseas staff? I am thinking, in particular, about health and social care staff coming from India and Pakistan, which is an issue that has been raised by constituents. Have the changes in relation to the post-study work visa had an impact?

Ron Culley: Not yet, but that does not mean that it will not happen. We need to be particularly vigilant as we move into political discussions over the next few years; we must be mindful that there are communities in Scotland that rely heavily on professionals from across Europe and, indeed, across the world. It is important that we are alive to that and that we make decisions based on the needs of the whole population of Scotland, not just those of the central belt.

I want to pick up briefly on the issue of partners and spouses, which is very important. I was fortunate enough to be able to move up to the Western Isles to a relatively well-paid position. Not everybody has that opportunity. My wife works as a clinical psychologist, and it was important for us that she had an opportunity to continue to work within her profession. We managed to do that, but we are one of the fortunate couples as regards remuneration and the opportunity that was available. The more structured we can become in supporting and facilitating such opportunities, particularly for those professionals who cannot rely on that level of salary, the better. If we consider workforces such as the home care workforce, we must be more strategic and collaborative about how we bring people in, and that must include thinking about how we can support partners and spouses into employment.

Dr Macaskill: I reiterate what Ron Culley has said. Our discussion about health and social care integration has focused quite a lot on the health workforce, but there is the potential to break down our siloed ways of thinking and working. That gets to the heart of the myths that exist about rurality and about professional status and value, not least around the distinction between nursing in the NHS and nursing in a care home environment. With regard to workforce planning, we must recognise the fiscal and resource realities. Attracting an individual to work as a social carer in rural Scotland is increasingly challenging, especially if

they have a spouse who will have difficulty getting a job.

On Brexit, I have said before to the committee that we have profound concerns, particularly in rural parts of the country, where a significant number of staff come from outwith Scotland. To answer Clare Haughey's question about whether there has been an impact on recruitment, it is too early to say, but in the medium to long term, we will have profound difficulties. Last week, I spoke to a major national organisation that said that it was having to close its recruiting office in continental Europe because people were stopping coming. That is the beginning of a sign that we will have difficulty in attracting people, particularly to lower-paid roles.

The Convener: I have a few people still to bring in. We are into our final five minutes, so I ask everyone to be brief.

Stuart Fergusson: In response to the point that it is sometimes the profession that makes it difficult for rural practitioners, I highlight that the Royal College of Surgeons of Edinburgh produced a document this year that endorses the value of rural surgery, and that was circulated to the group.

Bill McKerrow made a fair critique of the rural surgical fellowship. I agree that we should be training our own surgeons. That is the best model, and we need to make it attractive. Different service models will be appropriate for different rural hospitals, and in my view the model that we see in Wick will not work on an island in the long term.

In response to the convener's question about financial incentives, I note that, if we are going to make it attractive for those early-stage trainees to come, we need to give them a supplement. They might well be maintaining a mortgage in the central belt, they will certainly have significantly increased travel costs and they might need to meet accommodation costs where they are working. That must be part of the response.

The Convener: David, when we spoke to senior civil servants and the cabinet secretary about the NHS last week, the chief finance officer would not be drawn on the subject of cuts in the NHS and said that there are only efficiencies. However, you said earlier that there are cuts. Is that an example of the disparity between strategy and rhetoric and reality on the ground? I am asking you to justify your statement.

David Hogg: I realise that time is of the essence, but I have some figures here and I have two quick points to make afterwards. We know that waiting lists are going up. Six of the letters that I looked at last night were advising patients that they will have to wait a further six months for a routine cardiology review in Ayrshire. Apparently, that is affecting 320 patients in Ayrshire and Arran, whose appointment times have been extended.

The Convener: How long should they be waiting?

David Hogg: It varies depending on the review period that is set, so I cannot go into that much detail. However, we are seeing such things. Urgent gynaecology referrals in Ayrshire are up to about six weeks, and the waiting time for gastroenterology referrals in greater Glasgow and Clyde is 40 weeks. The one that really stands out for me is urology referrals in Highland. I have not seen the data, but I have reliable information that the waiting time for a routine urological appointment in Highland is 72 weeks. Those are not just individual things that are going on. We used to see such extended waiting times for pain clinics and cognitive behavioural therapy. We are feeling this.

Something that you said made me think of another point, convener. If I am in the Co-op and a patient has a cardiac arrest or there is a road accident outside, I want to be there. I am part of the community. However, increasingly, as the face of the NHS, we are having to answer for the cuts. My experience in the Co-op is sometimes more that people say, "I haven't had my referral through yet. Can you find out what is happening?" It is that kind of thing that gives us the goldfish-bowl effect. If there is a six-year-old having a seizure down the road, I want to be there.

I originally wanted to make two quick points. First, I highlight that I have confrères who trained overseas and have contributed a lot to the NHS. They are feeling vulnerable as a result of Brexit and some are already choosing to leave. That is going to compound the problem.

Secondly, I highlight the need for rural proofing. This is not all about money. We need to rural proof our policies and our management and examine things such as the Scottish terms and conditions agreement, which can have the effect of a 75 per cent pay cut for non-medical on-call staff in rural areas. Such things are not being rural proofed. We need to value people on the ground, particularly our care workers, whom we see as patients. That does not actually cost that much money. We just need to be a bit more sensible and holistic in our approach.

The Convener: I will bring in Bill McKerrow and then Gillian Smith, after which we will have to call it a day.

Bill McKerrow: David Hogg made most of the points that I wanted to make, but I want to respond to Clare Haughey. We see people from the Indian subcontinent coming in, largely to locum posts, on tier 2 visas. That system is still extant and it seems

to work okay. There are quite a lot of them, because there are quite a lot of vacancies.

Gillian Smith: We have done some work on the Brexit issue. It was done across the UK, so you will have to excuse me if I cannot tell you the exact figures for Scotland, which will be much lower. We reckon that, when Brexit goes ahead, if there is no commitment to the workforce, we will lose some 1,500 midwives. Some of you will know that England is 3,500 short at present.

In the next month to six weeks, the maternity and neonatal review will come out in Scotland. I cannot pre-empt that, but one of the drivers for the maternity review down south was around continuity of carer. There is no way that we can say that continuity of carer does not give better outcomes, but if we do not have the people on the ground to be able to deliver that, it is not going to happen.

The Convener: Thank you. We have a big panel and our discussion has not been the easiest to manage, but I hope that everybody has had a fair kick at the ball. If anyone wants to provide further information, I ask them to provide it to the committee clerks in writing.

As agreed earlier, we will now move into private session.

12:30

Meeting continued in private until 12:46.

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