OFFICIAL REPORT
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Public Audit and Post-legislative Scrutiny Committee

Thursday 2 November 2017

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

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PUBLIC AUDIT AND POST-LEGISLATIVE SCRUTINY COMMITTEE
25th Meeting 2017, Session 5

CONVENER

Jackie Baillie (Dumbarton) (Lab) (Acting Convener)
Jenny Marra (North East Scotland) (Lab)

DEPUTY CONVENER

*Liam Kerr (North East Scotland) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Bill Bowman (North East Scotland) (Con)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Monica Lennon (Central Scotland) (Lab)
*Alex Neil (Airdrie and Shotts) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

John Burns (NHS Ayrshire and Arran)
Tim Davison (NHS Lothian)
Caroline Lamb (NHS Education for Scotland)
Malcolm Wright (NHS Grampian)

CLERK TO THE COMMITTEE

Terry Shevlin

LOCATION

Committee Room 5

Scottish Parliament

Public Audit and Post-legislative Scrutiny Committee

Thursday 2 November 2017

[The Deputy Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Deputy Convener (Liam Kerr): Good morning and welcome to the 25th meeting in 2017 of the Public Audit and Post-legislative Scrutiny Committee. I ask everyone in the public gallery to switch off their electronic devices, or at least to switch them to silent mode, so that they do not affect the committee's work. We have received apologies this morning from Jackie Baillie.

Agenda item 1 is a decision on taking business in private. Do we agree to take item 3 in private?

Members *indicated agreement.*

"NHS workforce planning"

09:01

The Deputy Convener: Agenda item 2 is an evidence-taking session on the Auditor General for Scotland's report "NHS workforce planning". I welcome to the meeting John Burns, regional implementation lead for the west of Scotland and chief executive, NHS Ayrshire and Arran; Tim Davison, regional implementation lead for the east of Scotland and chief executive, NHS Lothian; Caroline Lamb, national board implementation lead and chief executive, NHS Education for Scotland; and Malcolm Wright, regional implementation lead for the north of Scotland and chief executive, NHS Grampian. As none of you has requested to make an opening statement, we will go straight to the committee's questions.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I have one or two random questions arising from the report. Clearly it is only a snapshot of about 60 per cent of the national health service workforce, and it is probably worth bearing in mind that we are not talking about 100 per cent of the workforce.

That said, in paragraph 50 on page 27, the Auditor General says:

> "There is a risk that the sheer number of workforce plans and the number of different workforce groups involved may itself become a barrier to effective working."

In section 4.2 of your joint submission, you say that it is not really clear how all of this is going to be handled. However, this is not something that has come up overnight—indeed, workforce planning has been on the go for a while now—and given that this is such a key area I find it a little astonishing that it is not clear how this is going to happen and that you are going to wait for a

"national workforce planning group"

to

"provide leadership".

Have you not been providing leadership in your own areas?

Tim Davison (NHS Lothian): I think that the difficulty has been that there have been too many leaders, all ploughing lone furrows. We have had policy leads at Government level; 22 health boards each determining their workforce plans; and councils producing their own workforce plans. Increasingly, nothing that we do in the health service can be seen as being divorced from broader public sector workforce and, in particular, health and social care workforce issues. Of course, we also have the new kids on the block—the 31 integration authorities, all of which have a

responsibility and a role in developing workforce plans.

The key thing for us in the Auditor General's report, which we agree with, is that it is now time to try to pull all of these lone furrows together into something more coherent. That is what has been lacking.

Colin Beattie: But this has been scheduled to happen for a long time; it is not something that has happened overnight. Pulling all of this together has been an aspiration for a number of years now.

Tim Davison: To be fair, the regions are very new constructs, and we have been appointed as regional leads only in the past six months. Moreover, integration joint boards have been in place for only 20 months. There is a new landscape and a new opportunity for us to work more collaboratively, and that is what we are seeking to do.

Caroline Lamb (NHS Education for Scotland): One of the other key recommendations from the Audit Scotland report relates to the data that we have and making sure that we are better able to use it and join it all together. A recommendation—or, I should say, an action—in part 1 of the Scottish Government's workforce plan is about clear leadership in pulling that data together. That is really important, and that work is now under way. We have some real opportunities to take new approaches to data and with new tools and techniques, not just use it to look at our current position but use it much more intelligently to forecast where we might be in the future based on multiple scenarios.

Colin Beattie: The top paragraph on page 9 of your submission says:

"Work is underway to try and bring key workforce data together into a single platform".

That sounds like a very big job. Has a budget been attached to it? If so, how much is it, and what resources are being diverted to doing that work?

Caroline Lamb: You are right—it is a big job. In the current year, NHS Education for Scotland has received an additional allocation of £100,000 from the Scottish Government to start work on it. It is also important to remember that there are lots of pockets of capacity and capability to deal with this in different organisations around Scotland. This is not just about getting additional funding but about making the best use of the resource that we already have in the system. It is also very much about looking at how we join up technologies, not just within health but more broadly.

We are working with the Care Inspectorate and the Scottish Social Services Council to pull together the data that we have in health and join it up with the care data. In fact, the first of a planned series of workshops involving interested stakeholders in health and care—and, indeed, wider than that—is taking place tomorrow to make sure that the way we are pulling the data together into a single platform responds to what stakeholders need.

Colin Beattie: But £100,000 is not going to take you very far with an information technology project.

Caroline Lamb: It is what we will be using in the current year to get the additional capacity and pull together the technical aspects of joining the data up; the challenge, then, will be to bring in data analysts and data scientists to make sure that we are able to make best use of it. There is the technical aspect to all of this, and then we have to take what we have, which has been described to me as an ocean of data, and turn it into a wealth of intelligence.

Colin Beattie: You have given some examples of the different IT systems that are going to have to be brought together. Given the sheer number of them, it seems like a very complex business.

Caroline Lamb: Indeed. We do not underestimate the complexity, but the issue is not about pulling all those IT systems together but about making sure that we are able to join up the data in them. It is not about trying to move to a single system in which we hold every bit of workforce data, but about creating a data lake that pulls the relevant data from those systems and is able to join it all up. There is some quite good experience in that respect. We can learn from the United Kingdom medical education database, for example, in the approach that we take.

Colin Beattie: I said that I was going to bounce around a little. In the last paragraph on page 10 of your submission, you say—

The Deputy Convener: I am sorry for interrupting, Colin, but I want to develop a point that you have just made. When you talk about this particular IT project, Ms Lamb, are you speaking for all of the boards? When you say, "We are developing this or that", are you saying that all the boards throughout Scotland are involved? I presume that there is a project team and that it is not just you who is dealing individually with this.

Caroline Lamb: No, it is not just me individually or, indeed, my team. All the boards in Scotland are involved, because they will be users of the data platform that we have been charged with developing.

As I have said, tomorrow we will be having the first of a series of workshops pulling together a number of stakeholders. We are in the early stages of this work, and we are starting to scope up exactly what is required, which will involve

identifying not only the data that we already have but some of the gaps where we might need to collect additional data to give us the best possible intelligence for the future.

The Deputy Convener: I presume that staff have been assigned to this work. I guess that that raises a recruitment challenge, but it also raises the question: when will this work be done?

Caroline Lamb: We have staff working on it at the moment. As I have said, we are still in the early stages; we need to understand the exact scope of the project, and that will be informed by the workshops that are starting to happen. We are starting to scope that up, and we are looking at having a proof of concept early in the next calendar year that will demonstrate what can be done with the data. However, it will be very much an incremental process; we need to start with what we have and look to develop that.

The Deputy Convener: But when will the work be done?

Caroline Lamb: I cannot give you the exact timelines at the moment.

The Deputy Convener: Can you speculate or give us a ballpark figure?

Caroline Lamb: I really do not want to speculate. At the moment, we are starting to understand what data we have and look at the complexity of joining it up. There is then another stage of identifying the data that we do not have, and another stage of complexity will be understanding how we pull all of that together. I think that it is premature to give timelines at the moment, but we are working very hard to get to the point where we understand exactly what we are able to do and how quickly we are able to do it.

The Deputy Convener: Thank you.

Colin Beattie: The last paragraph on page 10 of your submission refers to reducing senior management costs. Do you mean across the whole of the NHS or just in your own boards?

Tim Davison: I think that the figure relates to the whole of NHS Scotland.

Colin Beattie: The whole of NHS Scotland?

Tim Davison: Yes.

Colin Beattie: What were the actual cash savings?

Tim Davison: I do not have that figure.

John Burns (NHS Ayrshire and Arran): Neither do I.

Colin Beattie: Who would have it?

Tim Davison: I think that we can supply it to the committee subsequently.

Colin Beattie: I would be interested in seeing it.

On page 33 of our papers, which I think you have a copy of, it is suggested that, with regard to the impact of out-of-hours services, older general practitioners have been

"contributing on average a greater contribution of working hours than younger GPs."

Tim Davison: I am sorry, but our pages are not numbered.

Colin Beattie: I think that it is the final paragraph of the Scottish Parliament information centre briefing.

Alex Neil (Airdrie and Shotts) (SNP): It is section 4.

Colin Beattie: Do you agree with that analysis?

Tim Davison: I am sorry, but could you repeat the question?

Colin Beattie: It says in our papers that over the past few years older GPs working in out-of-hours services have made

"on average a greater contribution of working hours than younger GPs."

Would you say that that analysis was correct?

Tim Davison: Absolutely. That is what we have seen. One of the things that we allude to in our submission and which I think we need to talk about is the significant societal shift that we have seen in our workforce. Aspirations for work-life balance are far more apparent now than they have ever been over the course of my 34-year career, and that is reflected in the difficulty that we are having in staffing services that require intensive 24/7 rotas. It is certainly a very significant issue.

Another signal of this shift is the growth in less than full-time working. Because we pay our workforce across the NHS relatively well, staff can have a good standard of living working part-time and without the extra payments from providing out-of-hours services. It is the case that people are significantly and increasingly making work-life balance choices that are tending to move them away from intensive out-of-hours rotas.

Colin Beattie: In your submission, you say that the pattern of students in training seems to indicate that a large proportion of them will move into part-time rather than full-time work.

Tim Davison: Indeed.

Caroline Lamb: Instead of the number of students, we have set out the number of trainees, who are at a postgraduate training level. We have seen a consistent increase in the number of

postgraduate trainees training on a less than full-time basis. That will have two impacts. First, it will take longer for them to qualify as consultants or GPs; and secondly, it might indicate—we do not know this for certain—that they will be more likely to want to work less than full-time once they are fully qualified.

Malcolm Wright (NHS Grampian): I very much agree with the analysis, at least from my reading of Sir Lewis Ritchie's report. One of the points that he was trying to get over was the need to make it more attractive to young GPs to do some out-of-hours work, and he argued that if more GPs did such work—perhaps to a lesser extent—there would not be so much of a burden on some GPs who are perhaps coming to the end of their career.

I would also highlight the diversification of the workforce doing out-of-hours work. In recent years, we have seen quite an increase in the number of, for example, advanced nurse practitioners working alongside GPs to provide comprehensive out-of-hours care. The issue is not only about how we distribute the load among GPs, but about having a multi-professional workforce that can provide this service.

09:15

Colin Beattie: A lot of the older GPs are coming up to retirement. How do we cover that? We cannot just keep churning out more GPs. Is there an additional cost to the changing pattern of how GPs are working? How can you incentivise them? We talk about a work/life balance, but the fact is that we need people to cover these jobs.

Tim Davison: We do. I think it is a broader point. Looking forward to our workforce plans, we need to think carefully about who we are recruiting to medical schools and be clear about the requirement for 24/7 working if people want to work in the NHS.

Over the past few decades in the medical profession, there has been a tradition that junior doctors take the burden of the 24/7 workload and then, once a doctor becomes a consultant, they work more daytime, Monday-to-Friday hours apart from their on-call commitment. Compare and contrast that to the nursing workforce. Generally speaking, we recruit nurses with an understanding from day 1 that they are going to be working shifts and covering 24/7 workforce patterns. When we are thinking longer term—you will know from our submission that it takes a minimum of 15 years to train a consultant from start to finish—if we raise our gaze a bit and think beyond the next 10, 20 or 30 years, we have to look at the recruitment principles for bringing undergraduates into medical school and make sure that we are recruiting people who understand that a career in medicine in the future will involve significant 24/7 working.

Malcolm Wright: We are recruiting people into medicine in the context of a multi-professional workforce that includes advanced nurse practitioners, allied health professionals, pharmacists and radiographers who are taking on extended roles, and the pattern of the service that we have now is very different from what it was maybe 10 or 15 years ago. Societal expectations are really changing, as are people's expectations of having a work/life balance and the number of hours that they are going to work. As Tim Davison says, it is about the expectations of doctors coming into medicine, but it is also about diversifying and broadening the workforce that we have in the NHS in Scotland. During this evidence session, I will lead some examples of the things that are happening to make that a reality.

Colin Beattie: Who is going to drive that change?

John Burns: We are already driving some of that change. In my own board, in Ayrshire, we are diversifying the workforce in the out-of-hours area. We are bringing together not only the GPs, but advanced nurse practitioners and pharmacists. We are bringing social care into those teams, and we are bringing in crisis mental health teams. There is a wider multidisciplinary approach that is helping to reshape the service. It is about looking to the future and trying to ensure that we develop that workforce, because that is proving to be successful, and I think that it addresses some of the challenge around the GP workforce. That is where we need to focus in the broader workforce, because that will be where we will make a difference.

Colin Beattie: Is it up to individual boards to drive that change or should it be done nationally? How would it filter down to the level of people who are sitting in front of you and being told what their expectation should be?

Malcolm Wright: I do not think that it is an either/or situation; I think it is a case of both/and. The Government's policy around pharmacists, for example, is very much that they are going to work alongside GPs. We want to extend the role of pharmacists, so that is national policy. Pharmacists who are being trained at university and through their postgraduate education are being prepared for very different roles.

In NHS Grampian, for example, we have just under 60 pharmacists who are working in primary care settings alongside GPs, doing some of the work that GPs would have done before. It is partly a matter of national policy but it is also about making sure that such policies are implemented

on the ground in order to support GPs, who are under tremendous pressure at the moment.

Caroline Lamb: I will give you an example of the national element of that. There is a huge training programme to support pharmacists and pharmacy technicians in working alongside GPs and in GP practices. We have 178 pharmacists and 41 pharmacy technicians in those programmes. As Malcolm Wright says, it is a combination of the training that is being provided on a national basis to ensure that everybody is trained to the same standards and NHS boards being able to take advantage of that and pull those people in to work alongside their GPs.

Colin Beattie: What you are talking about will relieve the pressure on GPs at a local level, but it does not necessarily encourage them to do out-of-hours work.

Tim Davison: I think that it requires a national approach but also collaboration with the universities. The question that I was asking is really, projecting forward, what do we need from our workforce? Increasingly, particularly for unscheduled care services and critical care services, we need a workforce such as you have described, which is able to work 24/7. We have been more successful in getting that workforce in nursing, and there are lessons that we can learn from that. In essence, the expectation must be set for undergraduates who are considering entry into medical school that the health service needs to operate 24/7 and people should expect to work shifts for the majority of their career.

We also say that, looking forward, the normal retirement age for NHS staff is likely to be 67 or 68 fairly shortly, so we need to look at how staff towards the end of their careers, working into their mid and late 60s, can work in these intensive services. We may well have to front load quite a lot of that, with younger staff possibly covering the 24/7 shifts more than the older staff and older staff maybe having the opportunity to do a bit less.

Colin Beattie: Does that not emphasise the fact that work/life balance is an important factor for a lot of younger doctors? I am not sure that sitting a student down and saying, "If you go into this, you are going to have to work 24/7" and all the rest is going to persuade them to work in the NHS.

Tim Davison: Therein is the problem. We have some polarities here—some irreconcilables. Interestingly, we are now forming the view that we need 1.5 trained people for every medic who retires, to reflect the fact that people want to work less onerously and increasingly want to work less than full time. Malcolm Wright's point is that, if we have more staff working less onerously, that is a more attractive proposition. The problem at the moment is that, in particularly pressurised specialties, particularly in acute 24/7 services such as paediatrics, where we really struggle, the intensity of the 24/7 requirement puts people off.

Colin Beattie: Is what you are suggesting not going to result in a much higher cost to the NHS?

Tim Davison: Not necessarily if we have more people working fewer hours. Because, generally speaking, whole-time equivalent staff all have holidays, sick pay, leave entitlements and so on, there would probably be only a marginal increase in cost. Fundamentally I think that it is the answer. We must recognise that, increasingly among the workforce, we are going to have more staff wanting to work less than full time and less intensively out of hours. The only proposition is to have more people working fewer hours and less intensively.

Malcolm Wright: I am focused on how we make professional careers more attractive in Scotland. We are in a UK and an international labour market. What can we do to differentiate ourselves from other parts of the UK? One thing would be around pushing the whole multi-professional workforce to say to doctors who are coming through—be they GPs or consultants—"You're not on your own. The service doesn't fully rely on you—you are part of a multi-professional team."

An example of that is the work that has been led by NES and Caroline Lamb, which involves radiographers and developing radiographers reading images, reporting and working alongside consultants while doing some of the work that consultants would have done previously. We are seeing that development happen in different boards at different rates around Scotland, but it is happening. The notion is that the consultant radiologist, the radiographer and the technicians are working together as part of a multi-professional team. If we add to that good links with the universities and opportunities to do teaching and research, we create an environment that people will want to work in. We need to focus our energy on what can differentiate Scotland from the rest of the UK.

Caroline Lamb: I support that view. It is really important that we focus not just on doctors and nurses and what they have traditionally done but on the much broader team across NHS Scotland and look to ensure that every member of staff is able to contribute to the level of their skills. We must also have clearly defined career pathways for staff so that staff can see ways in which they can develop and grow their careers and we are able to make the best of their contributions.

John Burns: It is important that we recognise that we have started to make those changes. We have been looking beyond the traditional

workforce and considering how, with the professions that we have and the skills that they bring, we can maximise those skills. It is about the value that people have in the job that they do and the contribution that they make. We are seeing that across a range of disciplines. Colleagues have identified some of those areas, and it is something that we will build on, although it does not take away all the challenges that we face in workforce planning. We must plan not for what we had, but for what we are going to need in our redesigned health and care system for the future.

The Deputy Convener: Before I bring in Alex Neil, I will pick up a point that has just been made. Your joint written submission states that

"the continued growth of the workforce as a response is not feasible."

It continues:

"A continual expansion of the workforce would be neither affordable nor available."

It then states:

"The focus will therefore be on how we utilise the existing workforce and available future workforce differently and more effectively in the future",

which I think is the point that Caroline Lamb was alluding to. Your submission also says:

"There are c350 different NHS roles many of which have different training and education pathways. Within each of those, there are sub-specialities and roles which can vary greatly between departments, services and organisations."

If the intention is to meet future demands through staff redevelopment rather than recruitment, that has huge implications for the NHS. Is the NHS set up to do that? Are the training providers set up to do it? Are you really going to meet the challenge by recalibrating your entire workforce?

Tim Davison: We do not know yet. That is the huge problem. There is no plan, I think, at this stage, across Scotland or the UK, that accurately describes what a redesigned health and social care workforce might look like in the future. That is the huge challenge that the Auditor General is throwing down in her report. We have an aspiration to fundamentally redesign the way in which we deliver care, shifting the balance of care into the community. Increasingly, we are going to encourage our population to take more responsibility for their own health, to self-manage their conditions and to utilise digital technology and digital interactions with health rather than necessarily turn up at centres. Increasingly, we are going to have an integrated workforce in the community.

What does that mean? At the moment, we have consultant geriatricians, district nurses and social care staff. Increasingly, we are going to have to think about having a generic workforce that provides care right across the spectrum of health and social care rather than individual professionals who provide a little slice of somebody's care in the community. That challenge is at a high, rhetorical level. Some of us understand that challenge, but we are still a long way from distilling it into exactly what the workforce is, what its role is, what its job description is and what its grade of pay is.

John Burns: The introduction of regional delivery planning that we are responsible for leading on is giving us an opportunity to look across the west of Scotland and to think about the workforce in that wider context. As we rightly develop those plans, we will be bring forward what the workforce consequences are. We will then need to link that work with what is happening in the integration joint boards and ensure that the workforce planning is linked from those very local plans through to board plans and that, where appropriate, it is connected and linked into regional plans. As those service plans develop, some of the questions around what the future workforce needs to be like will evolve, but I think that that development will build on the work that we have already started.

Caroline Lamb: Another level of complexity in this area is that we also need to work with the regulators and with the professional bodies that set the curricula for many of our clinical cohorts of staff. The shape of training report on medical postgraduate training, which has now been signed up to by all the UK countries, is a really important development in getting more flexibility into medical training, which is absolutely what we need for the future. We just need to make sure that its recommendations now get speedily implemented through the regulators who have responsibility for this.

09:30

Malcolm Wright: I think that we need to work at multiple levels. There are UK dimensions to all of this, so decisions that the Department of Health at Whitehall makes on training numbers have an impact on the availability of training here in Scotland. We are making improvements in our national workforce planning, and we are at a reasonably early stage of our regional workforce planning. I think that health board workforce planning is well developed, too. Certainly, in NHS Grampian we know what our workforce is like and have a good idea of where we want to get it to as well as the measures that we need to take to get from A to B.

We need to be highly adaptive at a local level to changing labour market conditions. For example, we have worked with the University of Aberdeen around the introduction of physician associates,

which is a new role into which we can attract people from a science background who would not normally come into a health service career. We give them a three-year training programme with a degree certificate at the end of it as well as professional oversight and supervision, and they work to support GPs and consultants in NHS Grampian today. We have filled a number of places on that programme.

Having local adaptability and responding to local labour market conditions is also going to be really important. It is about striking a balance between having the national workforce plan with all the data in it and also having lots of flexibility locally to make things happen on the ground.

The Deputy Convener: I have a question to ask before the committee explores the issue further. I think that, at the start of the meeting, Tim Davison said that there is no plan, and the other panel members agreed with that. Did you really just say that we are sitting here with a crisis and there is no plan to sort it out?

Tim Davison: The evidence shows that, where there are multiple plans, there are probably too many plans. There is perhaps a distinction between the short-term operational plans that boards have hitherto been doing and what is now needed as a longer-term plan.

The Deputy Convener: Colin Beattie posed the exact question right at the start: who has not done it? With respect, it is not rocket science. Any businessperson knows that you develop a workforce plan.

Tim Davison: Collectively, across the entire system, we have to hold up our hands and say that we have not worked sufficiently together to align long-term future horizon planning with short-term operational plans, and that is what—

The Deputy Convener: Who has not done that, Mr Davison?

Tim Davison: All of us—from health board to Government—have failed to pull together the link between short-term operational delivery and longer-term workforce planning.

To clarify what I said about the plan, we are now being challenged by the Auditor General to come up with an explicit workforce plan that shows how, over the short, medium and longer term, we can fulfil the policy imperatives of shifting the balance of care from hospital to community and deliver some of the major policy imperatives such as improved elective capacity in hospitals. At the moment, we do not have a workforce plan that describes at national, regional and local level how we are going to do that, how much it will cost and where the workforce will be. Absolutely, that is now the challenge.

The Deputy Convener: I must say that I find that extraordinary.

Tim Davison: But that is what the Auditor General's report says.

Alex Neil: I want to explore the issue a wee bit further. Ever since I was Cabinet Secretary for Health and Wellbeing, I have felt as though we plan the journey for the next two or three years using the timetable from the past two or three years and that, fundamentally, there is a missing link. If the health service was a business and you were writing a business plan, the first line of it would be your sales forecast for the period of the business plan, because the number of people you need working for you, the skills you need, the location of those people and the equipment and estates you need—everything—would depend on your anticipated level of sales. You can never get it absolutely right, but the business plan is your planning tool and line 1 is the forecast for sales.

I tried to get staff to do that when I was the health secretary but, frankly, I could not find anyone who understood business planning in the whole of the Scottish Government. Surely, before we get into workforce planning, we need to understand the likely shape and size of the demand on the health and social care system over the next three and 10 years and, as Tim Davison rightly says, over a longer period.

We can be pretty sure about a number of factors. We know the forecast from the Registrar General on the level of population and we are pretty sure about the overall age structure, and we can break that down to regional and board level, because it is fairly accurate. We do not know what diseases are likely to emerge. We have all that stuff that you say about workforce planning, but we need some scenario planning. We had a report during the summer that pointed out that 25 conditions account for 70 per cent of NHS activity. Even if the planning was right in relation to that 70 per cent and not as accurate in relation to the other 30 per cent, at least that would be a major improvement on where we are today.

The starting point in all of this should be a proper systematic forecast of the shape and level of demand for the period covering the planning scenarios. Only when you know the level and shape of demand will you be in a position to decide on what kind of workforce you need, what size it needs to be and where it needs to be located to deliver on that level of demand. It would determine not just the workforce but things such as the shape of tomorrow's estate and the use of artificial intelligence. To give just one example, last week, the Japanese announced that they have developed artificial intelligence that can diagnose bowel cancer in 10 seconds with 98 per cent accuracy. If we introduce that in GP surgeries in

Scotland in the next two or three years, that will result in a lot of changes.

A plan is never entirely accurate, but surely the starting point has to be not how many workers we need but what the level and shape of the demand will be, because that determines everything else. Am I right that no work is being done on that in the long term?

John Burns: I agree that that is the starting point. In the work that we are doing in Ayrshire and in the early work that we are doing on regional delivery planning, that is exactly where we are starting. We are looking at the population health need and then trying to work through how, with innovation and technological change, we might deliver services differently and what the shape of the service model will be. I agree with you that that then takes us to understanding how, looking forward, we adapt and innovate around the workforce, our other services and our estate, infrastructure and assets.

Alex Neil: A plan is a dynamic document that needs to be updated at least every year to take account of the kind of changes that you are talking about. Even if it is a 20-year plan, it should be updated regularly to take account of developments, because a lot of them will be unforeseen. You say that that is happening in Ayrshire, but surely that is the starting point at a Scottish level.

John Burns: Yes.

Alex Neil: But it is not being done at a Scottish level.

Malcolm Wright: A lot of that information is available at a Scottish level.

Alex Neil: But it is not pulled together. We should have a national business plan for health and social care. I certainly tried to set one in motion, which at the time would have gone up to 2030. The first three years would be very detailed, because they would need to cover the budgets for those years and all the rest of it. Obviously, the further out it went, the more strategic and longer term it would become and therefore the less likely it would be to be as accurate as the plan for the first three years. There has to be a strategic document that includes an operational plan for the next three years, which is updated on a rolling basis every year and then pulled into one document so that everybody knows exactly what the plan is.

As Tim Davison rightly said, the problem is that there are hundreds of plans covering everything under the sun, with more than 53 organisations across Scotland involved in delivery, but nobody is pulling it all together. Surely the starting point is to bring together the forecast on the shape and size of demand over the planning period and then from that deduce the requirements on issues such as workforce, estate, equipment and finance. Surely that should have been done in one document. The Scottish Government, or the health service at a Scottish level, needs to do that.

Tim Davison: To go back to the earlier point, that is exactly what we have been saying. There are lots of plans: health boards have plans, although they have tended to be short term in nature, and now we have a new set of 31 integration authorities, which also have responsibility to develop workforce plans. Of course, we have 32 councils, which also have responsibilities for workforce plans. There is no lack of planning, but the issue is how it is all pulled together. The first recommendation of the Auditor General's report is about improving understanding of future demand to inform workforce planning.

Looking forward, the opportunity is that we will have a Scottish Government that is committed to pulling all of that together into a national workforce plan. We will then have regional workforce plans, health board plans and integration joint board plans.

Alex Neil: When is that going to happen?

Tim Davison: It is going to happen now and over the next three years. To respond to Mr Kerr's question about whether there is a plan, of course there is not a plan. We do not yet have a plan that reconciles the population demand that we face. The Auditor General's report that was published last week shows a significant increase in the over-65 population in Scotland at the same time as a reduction in the working-age population of 16 to 64-year-olds, while the health service is now going into real-terms reductions in funding. Our challenge is not just to pull together demand with workforce projections but to pull together service plans with workforce and financial plans.

Alex Neil: Absolutely, but my point is that that has to come together in one document.

Tim Davison: Yes.

Alex Neil: I used to work for a multinational that was three or four times the size of the health service in Scotland and we produced plans every year. We had long-range plans that were updated every year. In Europe alone, we were operating in 15 different countries, but it was all pulled together as a corporate plan so that everybody knew what the sales targets were and what they needed to do in terms of workforce and all the rest of it to deliver that. It is not rocket science.

I do not think that the expertise exists in the health service—I have not seen it—to bring a plan together in the way that it needs to be brought together, so we maybe need to buy in expertise to

get it done much more quickly. The message from the Auditor General's report last week was that it should be done sooner rather than later. I do not think that three years is an acceptable timetable to wait for a national plan that brings it all together. I understand the difficulties and challenges and how disparate the organisation sometimes is, particularly now that social care is part and parcel of the plan but, given the forecasting software that we have available to us nowadays, which is widely used in other health systems, not to mention the business planning software that we have, it is not beyond the wit of man or woman to pull the plan together in the next 12 months. The danger is that everybody is away doing their own thing and nobody is pulling the whole thing together, starting with that top level of demand.

John Burns: We now have the regional dimension, which we have been working on over the past six months. I agree that there will be some national themes and directions but there are population differences in the three regions. The west of Scotland is looking at that regional delivery planning for 2.7 million people. We are looking at the population health need and working with colleagues regionally and nationally to bring that together. The first plans have to be in place for March 2018.

Alex Neil: Is that for the workforce?

09:45

John Burns: No. The regional delivery plans look at how we deliver our services. They will not address everything.

Alex Neil: Will they include an assessment of the level and shape of demand for the longer term?

John Burns: Certainly in the west of Scotland, we are trying to start with the population health need because, by understanding that, we can then understand how we will adapt, and we need to adapt and change. It is about planning based on what we have and what the future needs to be, and it needs to be different—we need to adapt the workforce that we have, as colleagues have mentioned.

I agree with your fundamental point that we need to provide that strategic forward look, and that is what we have been asked to do through the regional delivery planning. We have been asked to use and understand as best we can the demand data, which is there and is certainly being used. It is complex, and we will have to look at the first three years but have a forward horizon for what we see ahead. As you say, we need to recognise that medical technologies change all the time, so we need to keep the plans refreshed and updated. Indeed, as our populations change and the demand changes, we need to be able to reflect that in the plans.

Alex Neil: Will that include a financial plan?

John Burns: Yes. It needs to have a strategic resourcing framework.

Alex Neil: A big fault in the national delivery plan is that it does not mention funding. It does not look at where the funding will go. A genuine plan has to have a financial plan as part of it.

John Burns: Yes. We need to have all the elements that you have described, including the workforce elements and the strategic resourcing elements.

Alex Neil: Will the other two regions be doing the same in the same timescale?

Tim Davison: Yes.

Malcolm Wright: Yes.

From a north of Scotland perspective, we have a pretty good handle on the demography in terms of the burden of disease, the changing age profiles and what people are going to need. Each of the regions requires a slightly different workforce profile. The north of Scotland covers about 60 per cent of the landmass of Scotland but has only 25 per cent of the population, much of which is dispersed in remote and rural communities. We need and are going to need more people with more general skills who can work with people in local communities and we need to use technology so that people do not have to travel to specialist centres when they do not need to.

We have a pretty good idea of the money that we have in the system. We try to forecast where we think public expenditure will go and the envelopes of money that we will have to work with. We have a pretty good handle on the shape of the workforce in the north of Scotland. We are considering how, if we will not be able to hugely increase the workforce in terms of overall numbers—I do not think that that is a realistic possibility—we use the workforce that we have in a different way. We are considering how we diversify the workforce, give people more general and broader training and how we expand people's roles so that they are fit for the future burden of disease and morbidity.

Workforce planning is important, particularly to inform Caroline Lamb and the Scottish Government on the required undergraduate, postgraduate and nursing training numbers. That is helpful but, as we said in our written evidence, the process has a really long timeframe and we can be absolutely sure that, when we make a decision, by the time those people graduate, things will have happened that mean that we will

be living in a very different world. Therefore, my point about adaptability is very important.

In the north of Scotland, I think that we have a handle on the issues. We have a handle on the money, we know the burden of disease and we know what kind of distribution of services that we want. It is about growing those generalist skills in our workforce in the future.

Alex Neil: That was helpful. I want to focus a wee bit on the pipeline from undergraduates into medical school. Your paper states:

"Last year 860 Scottish domiciled school leavers applied to medicine through UCAS for the first time"

but that

"Scottish medical schools were seeking to fill"

only

"834 home fee (UK and EU) places in that year."

However, the first striking thing in the paper by the Scottish Parliament information centre is the lack of proper data on applicant drop-out rates, destination figures and all the rest of it; the absence of reliable data is astounding. I do not think that it is the fault of the health service; I think that the Scottish Further and Higher Education Funding Council is slacking, so we need to write to it to rectify that. How can the health service plan ahead if such basic raw data are not available? The data should be easy to collect. I can list later for the clerks what I think is missing.

Let us look at the figures. The University of Edinburgh had 1,372 Scottish/EU applications for the medical school last year. It made 192 offers and the intake was 115, which was 60 per cent of the offers. My point is this: if of 192 offers to Scottish and EU students only 60 per cent of applicants take up the offer—I realise that there may be a bit of fat in the number of offers—we surely need to increase substantially the number who are recruited if we are to have the pipeline of medicine graduates that we need.

I had a letter just yesterday from a constituent who is a young woman of 18. She has all the qualifications that she needs to get into medical school, but has been turned down. I presume that all the 1,372 applications that I mentioned met the entry requirements or they would not be treated as applications. Only 192 offers were made, and from 1,372 applications we end up with an intake of 115. We cannot go on like that. We are always going to have a doctor shortage unless we train far more doctors.

I understand that it is difficult, because of the percentage who want to become GPs, to fill the training posts: Tim Davison referred to some of the reasons for it that need to be addressed. We will continue to have overall shortages if we do not recruit many more people into medical school. We all know that Scotland-domiciled applicants are more likely eventually to practise in Scotland, and that people from rural areas are much more likely to practise not necessarily in the rural area that they come from, but in a rural area.

Do we not need to do much more? I know that we have recently increased intake by 100. I do not know whether that is for this year or next year, but it seems to me that we need to go a lot further if we are to get the pipeline of undergraduates and graduates that we need for tomorrow's world.

Caroline Lamb: I will make a number of comments in response to that. Your point about data was well made. The Auditor General has suggested that it would be helpful if the NHS could track that data. Within NES we already index every undergraduate student who starts on a nursing course. We have done that for years and it has proved to be incredibly useful in tracking attrition and completions, and in being able to see where graduates go for employment. We would welcome the opportunity to do exactly the same with medicine undergraduates. That is my first point, because I think that it is very important to be able to track those folk and to see exactly where they go.

Alex Neil: Will that happen soon?

Caroline Lamb: I hope that it will; we are working with the Scottish Government and others on that.

Alex Neil: Surely that should be treated as a matter of urgency. How can we do workforce planning if we do not have the basic raw data that are required?

Caroline Lamb: I agree. That relates to what I said earlier about the need to identify the data that we do not have, and to make sure that we are able to get that data. That is absolutely part of the work plan.

The second thing that I will say is that we are clear that the evidence indicates that we are more likely to retain doctors in Scotland if they came from Scotland. We need to be careful with some of the data, because there is obviously a difference between the numbers of applications and applicants. Applicants make multiple applications, which partly explains why offers are not accepted: applicants make applications to more than one institution, and the institutions might be in Scotland or outside Scotland.

There is a real focus in the Scottish Government on trying to increase the number of graduates who stay in Scotland, on trying to widen access to medical school places and on trying to encourage our undergraduates to think about general practice as a career.

You are right that the number of places in undergraduate medical schools has been increased: there was an increase of 50 for 2016's intake. There has also been the establishment of ScotGEM—the Scottish graduate-entry medicine programme—which is absolutely focused on general practice and on attracting students from wider-access backgrounds. It will take its first intake of 40 in 2018. The Scottish Government has recently written to all universities asking them to submit proposals that would help to fulfil the strategic objectives of retaining more doctors in Scotland and attracting more doctors into general practice. It is seeking to add between 50 and 100 undergraduate places to the system through that, which would be very welcome.

Malcolm Wright: We need to see—I think that we do—universities' medical schools as key partners in this work. I fully support what Caroline Lamb said. There is also a local element: there is evidence that people who grow up in an area and then go to medical school within the area are more likely to stay within that area.

The widening access programme in my local university—the University of Aberdeen—has had 20 people coming through to it who would not otherwise have done medicine degrees. That is hugely encouraging. The local element in all this is the university and the local health and social care system working hand in glove to draw out of the local population people who have the ability to study medicine, and to support them through a medicine degree. Such people might have thought that medicine is not something that they want or would expect to do, but if we create that expectation in them, and then really support them to get them through the medicine degree, they will be more likely to stay in Scotland and to stay local. That is what we are currently doing.

Alex Neil: Data on drop-out rates is also missing. I know that we had, at one time, a real problem with the drop-out rate among nurses; I think it was at 35 per cent. It is much less now, I think it is substantially down.

Caroline Lamb: I think that the rate has improved 1 per cent year on year.

Alex Neil: What is it now?

Caroline Lamb: I cannot remember, off the top of my head. I can get that information for you.

Alex Neil: We do not know what the drop-out rate is for medical students after the second year.

Tim Davison: You mentioned the University of Edinburgh and I just thought that we should make one or two points specifically about how we are trying to make links between the multiplicity of local individual plans in order to bring them together. A number of us were in a recent meeting with Government and all Scotland's universities to consider how to increase not just the number of student places, but the number of Scotland-domiciled students—who are more likely to stay in Scotland. The figures to which Alex Neil referred—the 1,300 or so applicants—are for Edinburgh university. Caroline Lamb's point is important: candidates might apply to four places or more. The number of applications can probably be divided by four to find the number of individuals. The number of Scottish applicants and the number of Scottish offers are actually very close. The numbers of Scottish applicants is falling at the moment.

The number of places is controlled by Government. I think that Alex Neil mentioned that Edinburgh university offered only 115 places: it is only allowed to offer 115 home student places. The numbers and proportions of rest-of-world, rest-of-UK and Scotland-domiciled students are set. The point I was making earlier in response to Mr Kerr is that universities have their plans, Government has long-term plans and health boards have had short-term operational plans. We are absolutely wedded now to trying to pull the whole lot together so that they align.

10:00

The problem is that because we currently have broadly similar numbers of Scotland-domiciled applicants and offers, we need to grow the potential pool of applicants from Scotland. That includes, for example, work being done in the most disadvantaged communities. At Edinburgh university medical school in 2017, 30 of its 115 places came from the two most-deprived quintiles of the Scottish school population. That shows how the endeavour to increase the number—and the pool in which the universities fish for candidates for medical school—is causing improvement.

Alex Neil: With regard to the 860 applications through UCAS, is that the total number of applications or is that just the number of applications that use UCAS? In my day you could apply directly to universities or through UCAS or both.

Caroline Lamb: It is my understanding that all applications now go through UCAS. I will need to check but I think that the figure that we quoted concerned first-time applicants, and there will also be some applicants who are applying for the second time.

Alex Neil: Yes, it was the first-time applicant figure. Clearly we have a job to do. Part of it concerns the issue that supply can sometimes create demand in itself—increasing the number of places can generate more demand because, at

the moment, some people are put off because they think that the chances of getting in are so low.

Caroline Lamb: That is an interesting point, because the data from the 2018 application cycle shows that there were 920 applicants from Scotland.

Alex Neil: That is moving up, which is good.

Caroline Lamb: That would indicate positive movement, yes.

Alex Neil: Maybe we need to do a bit more. It is like the situation in the construction sector in that it is difficult to get young people to go into that sector because of the image that it has. Obviously, we have a lot more work to do in the schools to try to get these bright pupils to apply for medical school.

I would just like to finish up with one question on a related but different subject: the impact of the pension changes. I think that I am right in saying that, in 2010, someone could build up a private tax-free lifetime-allowance pension fund of £1.8 million—for a lot of people listening out there, that is a lot of money. After a number of changes, that figure is now down to £1 million. You can put a maximum of £40,000 a year into your pension fund, tax free, so it does not take a lot to work out that, after 25 years of maximum pension contributions, you will have reached your lifetime allowance. From talking to my own GP, to numerous GPs in Ayrshire when I went down to meet them and to many other GPs across the country, I know that, although they do not make a big issue of this publicly, privately they say that they are retiring early because of those pension changes. A number of them are retiring on the Friday, collecting their private pension on the Monday, and then maybe working a couple of days a week as a locum. A lot of those people who previously would have probably carried on until 65-ish, or certainly into their 60s, now retire at 55 or 56. We get them for two days at roughly 180 per cent of what it cost to employ them the previous week, and we then have to employ locums for the other three days—because the original GP is not there—at 180 per cent of the average cost of a GP under a normal contract.

We are not in charge of pension policy, and you are not in charge of pension policy. None of us was consulted. The consequences of those changes were never properly examined, but we know from talking to GPs that one consequence is the early retirement that I have described, and that we are losing a lot of GPs who otherwise would have been happy to work on, but who do not now see the point. I remember that, in the year in which the third change was made, the availability of GPs for out-of-hours services in the Greater Glasgow and Clyde Health Board went down by 40 per cent. When we spoke to a number of the GPs in their 30s and 40s, they said, "Well, what is the point of doing out-of-hours work? It just means that we can retire at 52 instead of 55."

What can we do about it? We are in the middle of GP contract negotiations. It seems to me that one of the things that we should be looking at is whether GPs can go into a kind of pension scheme that is similar to other pension schemes in the NHS: a superannuation scheme that does not necessarily have the same limitations to the same extent.

Tim Davison: Those are Her Majesty's Revenue and Customs rules. They apply whoever the employer is, whether you are in the public sector, the private sector or whatever.

Alex Neil: I am just asking whether there is something that we can do to deal with the consequences of those changes, because they are one of the reasons—not the only reason—why we have this increasing shortage of GPs.

Malcolm Wright: I do not have data on that, but, like you, I speak to a number of doctors and I know that it is an issue. It is a very good example of the limitations of workforce planning, because it shows that things such as changes to taxes on pensions can have a profound impact on individuals and the decisions that they make about their future, and that that impact is out of our control—it is not within the control of Scotland.

Another example of that, which we have mentioned in our submission, would be the withdrawal in 2006 of permit-free training. My understanding is that, subsequently, we went from taking in 4,000 doctors from the Indian subcontinent to about 400. That is the sort of thing that you cannot predict within a workforce plan and, if it happens, you need to adapt to it. Part of that adaptation concerns how we can incentivise doctors to continue in their careers. We need to think about what would make it good for them to continue to offer their service, because, at 60, many of them are in the prime of their careers, they are very experienced and they are really good diagnosticians, which means that losing them from the NHS is a major loss. What can we do to help them to continue to work?

Tim Davison: Again, there are short, medium and long-term views of this. Like you and Malcolm Wright, I think that, anecdotally, people have decided that it is no longer worth working to reach their lifetime allowance, so they retire early. Obviously, as I said earlier, as the younger workforce matures over time, the normal retirement age for NHS staff will be 68, and people will calibrate their working careers based on not getting their occupational pension or their state pension until they are 67 or 68.

That is the case at the moment but, in the medium to long term, that will change. I will come back to doctors in a second, but there are also short, medium and long-term issues around nursing. We still have a generation of nurses who, when they were employed 30 years ago, could retire at the age of 55, and mental health officers who had mental health officer status who could retire at the age of 50. We are seeing the spike of that generation getting to the ages beyond 50 and towards 55, and they are taking retirement. The new generation of nurses coming into the profession will be on a different set of terms and conditions. We no longer have the mental health officer status, we no longer have the special classes of early retirement, so we are in an interim period as people in my generation come towards their mid to late 50s and the younger generation comes through. As unpalatable as it might seem, in the short to medium term, we have to get people in my generation back beyond retirement. We have to have a plan that says, "Take your retirement and come back."

Alex Neil: What is your plan? That is what I am asking.

Tim Davison: We are doing return-to-practice work and we are trying to be as flexible as we can be in relation to someone who says, "I am going to take my pension so, if you do not allow me to come back to work, that is fine, I am still leaving but, if you want me to come back and work, I am willing to come back, perhaps part time."

Until the generational change that I described takes place across medical staff and nursing staff—that is, for the next decade—we are increasingly going to have to be encouraging people in that generation to come back to work.

Alex Neil: Do you have any figures for what percentage are returning to work, even if it is part time?

Tim Davison: I do not, but we have an increasing return-to-work number.

Alex Neil: Can we get some figures on that, if you have them?

Caroline Lamb: I can give you numbers on nurses. We have 364 who have started on return-to-work programmes and, of those, 246 have completed the programmes and are moving into employment. I cannot tell you the stage in their career that those people were at. They may well have been people who took time out for other reasons.

Alex Neil: I am particularly interested in GPs who have retired and returned to work or not returned to work and, whether any return to work has been on a part-time basis.

Tim Davison: Those numbers will be difficult to get because, of course, the vast majority are independent contractors and their numbers are not centrally recorded.

Alex Neil: But surely, in terms of workforce planning, that information should be getting collected?

Tim Davison: It currently is not.

Alex Neil: Should we rectify that?

Tim Davison: Possibly, but at the moment independent contractors do their own workforce plan.

Alex Neil: Yes, but they are contractors to the health service.

Tim Davison: Indeed, but not as individuals; they are contracted for a practice.

Alex Neil: Yes, but surely we can ask the practice for the information?

Tim Davison: We can ask, yes.

Alex Neil: As the Auditor General said, we need a far better grip on the data around GP practices, and it seems to me this is a pretty important bit of data that we should be collecting.

Malcolm Wright: Yes, it is important. However, as Tim Davison says, they are independent practices and I do not think they are under any obligation to disclose that data.

Alex Neil: Hopefully under the new contract they will be.

Malcolm Wright: Through the integration joint boards, we have a pretty good sense of where our practices are, who is planning to retire and who will be returning to practice. We need to aggregate all of that to see the whole set of national trends. GPs and consultants are making decisions because of the pension rules, and we need to think about what we can do nationally to give greater incentives to keep them in practice.

Alex Neil: If you look at the Auditor General's report of last week, you will see that that is the kind of information on GP practices that absolutely needs to be systematically collected. I realise that under the existing contract there is not a contractual obligation, but that does not stop us asking for it. Some may give it and some may not, but if you get enough of a return to see where the trends are, that will help. I hope that, in the new contract, there is an obligation to provide the required data, because we cannot go through another 10 or 15 years without getting the data that we need from GP practices. If we do not get that data, workforce planning and that whole chunk of work in the health service will be meaningless.

The Deputy Convener: Thank you.

Tim Davison and Alex Neil talked about pulling it all together. Who has ownership of pulling it all together?

Alex Neil: The Scottish Government.

Tim Davison: Yes. Fundamentally it is the Scottish Government, but increasingly we are working towards that aspiration in a more collective way, as I said earlier. Previously, the Scottish Government had the policy imperatives around the long-term planning, the undergraduate numbers, the training numbers and so on, and boards were focused on short-term operational delivery plans of perhaps only one year, or two or three years. As we said earlier, our plans need to be for a minimum of 15 to 20 years if we are talking about the medical workforce. Increasingly, the Scottish Government is working with the three regions, their constituent health boards and IJBs, and partners—councils and universities—but, ultimately, the Auditor General has challenged the Government to produce a workforce plan for health and social care in Scotland. Pulling that plan together will be the Government's responsibility.

The Deputy Convener: I want to be absolutely clear. If I am sitting here in three years' time and we are having a similar conversation, are you saying that it will be a failing of the Scottish Government, which has ownership?

Tim Davison: You are putting words into my mouth. All of us, as accountable officers within the NHS, have a collective responsibility to work together, but the Government has responsibility for pulling it together, absolutely.

Monica Lennon (Central Scotland) (Lab): You said that the health boards and the Scottish Government have failed, collectively, to co-ordinate sufficiently. Can we keep the focus on patients? Can you explain, in terms that the public can understand, what the consequences of that are—and will be—for patients if we do not start to get this right?

Tim Davison: The immediate consequence is perhaps around the failure to recruit to GP vacancies. For example, that could lead to GP practices not being able to register new residents when they arrive in an area—that is a significant pressure in Edinburgh. We also have restricted lists; if a family has a child the child will be registered, but someone new who comes into the area will not be registered and the health board has to reallocate that person to a practice that might not be within their immediate locale.

10:15

Another consequence might be that GP practices fail and collapse because they cannot recruit staff and the health boards have to step in and directly manage those practices. That has been an increasing phenomenon across Scotland. In my patch in Lothian, over the past five years, we have had an increase in that from perhaps two or three practices failing in a year to seven or eight practices failing in a year. The population context is important here. When a health board steps in to recover a failed practice that has been unable to recruit to vacancies—usually because of retirements, or people going on maternity leave or whatever—we have to create what is known as a 2C contract, in which we directly employ the staff and run the practice as though it was a directly employed bit of the NHS.

Our latest data for the current year is that the number of practices that are being directly managed as a consequence of GP practices not being able to recruit represents about 5 per cent of our patient population. On the other hand, the very reason that we have stepped in is to ensure that those practices then continue to provide services. Patients should not see an on-going impact beyond the short-term disruption that often occurs.

Thirdly, there is the significant increase in waiting times for elective services, which is a consequence of not being able to recruit sufficient numbers. There are real hotspots for that. Sometimes that is not a failure of workforce planning, but the coming together of a range of issues that are difficult to predict. For example, looking at my urology team at the Western general, my medical workforce vacancy rate in Lothian across the piece is currently 4.8 per cent. However, in particular specialties on particular hospital sites, as the result of maternity leave, genuine long-term sickness absence or vacancies, we have a vacancy rate of something like 27 per cent. When that happens, urgent cases and cancer cases are prioritised, while routine cases are prioritised at a lower level so that patients have to wait longer.

In all those cases, as I hope that I am expressing to you, we have a huge responsibility and an ability to step in and mitigate the impact.

Monica Lennon: When GP practices fail or collapse and the health board has to step in, you have explained that the service continues. However, is that sustainable and what impact does it have on NHS boards as a whole? That is a lot of pressure to absorb.

Tim Davison: Increasingly, I think that the resilience of practices will be based on bigger population sizes. Generally, practices fail because they are relatively small—they are either single-

handed practices, or perhaps there are two or three doctors working in a practice.

My personal view is that the resilience of a practice is greater if there is a bigger practice population, with a bigger number of GPs working in it. In a single-handed practice, one maternity leave is a 100 per cent deficit. However, it is not just in such circumstances that bigger practices are resilient. I spoke earlier about how onerous the work is, and I think that bigger practices generally allow a better spread of the onerous tasks, particularly when the practice offers early morning and late evening openings and that kind of thing.

At least part of the answer lies in encouraging what we are beginning to see, which is practices merging, neighbouring practices taking over failed practices and so on. That is a significant part of the solution.

Malcolm Wright: Such solutions can work well in inner-city environments or in large towns and settlements. However, once we get out to remote and rural areas of Scotland where peripherality is a major issue and we have very small, single-handed practices, if that one GP decides, legitimately, to retire, suddenly we have some real problems on our hands.

I return to the point about adaptability. It is the board's responsibility—we do this to get close to practices—to keep in touch with such practices and to diversify the workforce within the practices so that they are not completely dependent on individual GPs. What might work in a large urban area will definitely not work in a remote and rural area, so I think that the solutions need to be different.

John Burns: The point has been made about working with GP practices early on, at the first sign that they are feeling under pressure or there is a risk factor or vulnerability. In Ayrshire, we have been working with the practices to try to support them to continue. Where they cannot continue, we step in—increasingly by using multidisciplinary teams, including pharmacy and physiotherapy—to enhance and support that practice in meeting the needs of the population. Early engagement is very important.

Monica Lennon: In earlier questions and answers, it came across that there is not a lack of leaders at the top of the NHS, or indeed in the Government, but a lack of leadership. You are all in the hot seat today, but this is not about pointing fingers; we are all looking for ways to improve. What would your message be today to other colleagues, to people who are listening to our meeting and to people who read the *Official Report* afterwards? We will probably take further evidence. What can colleagues do, and what can people who are passionate about the NHS do, to work differently in order to achieve more shared outcomes?

Malcolm Wright: One message would be that we are completely committed to the NHS in Scotland and to a sustainable workforce within the NHS in Scotland. We are committed to giving that leadership alongside clinicians, GPs, consultants and nurses; to diversifying and supporting the workforce, and ensuring that the workforce is trained; and to recognising the challenging financial situation that we are heading into. We will not be able to expand the numbers significantly within the NHS workforce. It is about support, training and diversification.

Workforce planning is important, particularly for the undergraduate and postgraduate numbers, but it can take us only so far. Flexibility and adaptability will get us to a point, but there will be things coming across the barriers that cannot and will not be predicted. With a combination of the work that Caroline described and what we are doing at a very local level to support practitioners, I hope we would all agree that our role is to lead that change and to support and encourage our staff in doing so.

John Burns: I am seeing strength of leadership across the NHS and all the professions, and some very strong clinical leadership. We need to look at the opportunities, to recognise the need to adapt and perhaps to change how we do things, and to look at the workforce differently. We have come a long way and the professions have worked to help evolve and make some of those change. People who are in leadership roles and beyond—many people are in different types of leadership roles—are beginning to coalesce around this work and to see the importance of it. I am encouraged by that.

Tim Davison: I agree with all that. The reality, as we can see from the figures, is that our population is growing, the older population is growing, our working-age population is reducing and our real-terms funding is declining. That reality means that even all that will only take us so far. Earlier, Mr Neil mentioned the introduction of new technology—there are robotics, artificial intelligence, new technology, and alternatives to traditional workforce models. A couple of weeks ago, in a media report from south of the border, we heard about digital reminders being used to support medicine compliance for people living at home rather than home visits from a carer.

All that, and probably a raft of things that we have not even thought of yet, has to be in addition to all the flexible workforce requirements, because the arithmetic just does not stack up. The working-age population is not growing in pace with our overall population so we need to have workforce solutions, but we also need to have supplements to people.

Caroline Lamb: We are starting to see people working together much better. Even in the short time for which regions have been established and the national boards have worked together, we have seen a change in what we are able to achieve and the pace of that, too. It is about bringing us together collectively; the IJBs understand the particular circumstances and their localities, and that can be pulled together with the health boards and, increasingly, the regions. Collaborative working is crucial in getting us to a better place around all this.

Malcolm Wright: There has been a step change in that collaborative working across the board boundaries, certainly within the north of Scotland. Colleagues have described it as a sea change and a difference in attitudes. Take a hospital such as Dr Gray's in Elgin, where there have been some well-publicised staffing challenges. There is a real recognition that part of the solution is not just working with Aberdeen royal infirmary, but working across the health board boundary with Raigmore in Inverness. Very active discussions have been going on there at a rate that would not have happened six or nine months ago. The move towards seeing things in a regional dimension as well as an individual health board dimension is starting to gain currency.

Monica Lennon: It is good to see some cultural change happening. Some of my colleagues on the committee have better business brains than I do. I guess that the public and private sectors can learn a lot from one another, but the NHS is not a business with shareholders and customers. It is a public service. It is our beloved NHS, and patients, to be frank, do not have anywhere else to go unless they can afford extortionate private healthcare. I know that in some cases, constituents of ours are having to beg, steal and borrow because they are desperate as they have been on waiting lists for 12 months or longer.

There was a health debate in the Parliament yesterday. Our acting convener, Jackie Baillie, is not here today, but she read out a long list of her constituents who have been waiting for knee operations and other types of treatment for longer than a year. Shona Robison, the Cabinet Secretary for Health and Sport, said that it is not good enough. She is quite angry about that, but we are all getting constituents coming through our doors and emailing us and we are hearing real stories of distress. Is there a point at which we have to say to constituents that there is an inevitability about some of this?

Tim Davison: I think that there is an inevitability about trying to reconcile the policy imperatives that we have. We are trying to juggle them, whether we are wearing our health board hats or our regional hats. We have a statutory duty to live within the resources that are available, and those resources are now declining in real terms, as the Auditor General's report says. We have a statutory duty to shift the balance of care and support and improve primary care—we have talked a lot about GPs, for example—and we also have to improve our deteriorating performance on waiting times.

At the moment, those three things can appear to be quite difficult to reconcile. We have to save the most significant amount of cash that we have ever been challenged to save, whether that is 4 or 5 per cent a year, on a sustainable, recurring basis. Those cash savings have to come out of the system in order to cover the fact that our costs are growing faster than our inflationary uplift, whether that is to fund drug inflation of acute drugs at 8 per cent a year or GP drugs at 4 per cent a year.

At the moment, it is looking extremely difficult to reconcile the saving of 5 per cent a year on a recurring basis in order to fund demographic pressures and prescribing growth, for example, with the improvement of access to elective targets and the improvement of resource allocations to primary care. To be frank, I think that the bigger macroeconomic policy issues for both this Parliament and the UK Parliament around the responsibilities of citizen and state and issues around income tax, for example, are really important here.

It is becoming clear to us—and this is the challenge that the Auditor General lays down for us—that we now have to reconcile that in our plans. We are developing our regional plans and the national boards are developing their equivalent plans. All those plans will then come together for the Government. We will address the challenge that the Auditor General has laid down, which is, "We need your service plans to be reconciled with your financial plans and your workforce plans." If, as a consequence of that, we say that our view is that the workforce that we need is neither available nor affordable, that will generate a different conversation about how we are going to respond to that at both the political and service delivery levels.

That is really what I meant by what I said to Mr Kerr about us not having a plan. There is currently no published plan that reconciles our service aspirations, our financial requirements and our workforce requirements. We need to pull that together.

10:30

Monica Lennon: Before I came to Parliament, I was involved in a different kind of planning, as I am a town planner. I would never say that we could have too much planning or too many plans. However, on the point that you have just made,

before we can start to develop a plan, we need to have a real vision of what we are trying to achieve. Is there clarity around the vision?

Tim Davison: There is clarity around the vision. The lack of clarity is around how we will get there and over what timescale and how much it will cost. Alex Neil said, "Can we not do this in 12 months?" If it was simply a question of saying that our elderly population was going to grow by 40 per cent in the next 10 years and asking what that would mean and how many more GPs, district nurses and whatever we would need, we could say, "We'll need 20 of those, 40 of those and 100 of those, and that will cost £50 million." However, the reality is that in the short to medium term—in the next five or 10 years—we are not going to have 40 more GPs or 40 more geriatricians, nor are we going to have the resource to pay for it. The 12-months challenge that Mr Neil put down is extremely challenging.

The alternative plan has not been invented yet. That is what the integration authorities and regional plans are about, and it is what the need for innovation is about. We have got to come up with solutions that, to be frank, have not been invented yet—not just in Scotland, I might add, but across the western world. This is not a uniquely Scottish problem.

Monica Lennon: I would like to open this discussion up to the rest of the panel. In previous evidence-taking sessions, particularly when we have looked at the integration of health and social care, we have been reassured that integration is not new and that people in the NHS and the Government have been doing it for quite a long time, but that the boards are a relatively new creation. Previously, I have taken comfort that this type of collaborative working is not new and that we are not starting from a standing start, but is that right? I feel that we are getting mixed messages.

Malcolm Wright: It is a different dimension with the integration joint boards. It is true to say that we have always worked together across health and social care and we have had various initiatives over the years, but the IJBs take that to a new level.

In my local patch, the number of delayed discharges from acute hospitals has been halved in the space of about 18 months. I put a lot of that down to the relationship between the chief executives of the board and the local authority, the appointment of good chief officers, and those people working together collaboratively to make changes to where patients are cared for so that we do not have patients staying in hospital who should not be there. They are also making sure that the IJBs are not doing things that create a negative effect. We are very much looking at the whole system. We are seeing changes in occupied bed days for unscheduled care across Aberdeen city, Aberdeenshire and Moray. That is all good.

The challenge in elective care that Tim Davison talks about, which affects people who are waiting for out-patient appointments and operations on hips and knees, cataracts and those sorts of conditions, is very significant. To pick up on Mr Neil's point, when we look at the population profile and the morbidity profile that we can predict, we see that that is going to be a real challenge. One thing that concerns me as an accountable officer is the ability to care for that population and make sure that those people get their operations when they need them.

John Burns: I agree. We have been working collaboratively and in partnership for many years, and beyond just in health and social care. We have been doing that much more widely in our communities.

In the Ayrshire context, the introduction of integration joint boards has created a much stronger local and community focus on planning and how we look to shape services. It has allowed us to have stronger partnership and collaborative links with education, the third sector and other parties. It is still in the fledgling stage of its life, but we have seen change.

However, as we have said throughout our discussion this morning, we need to make sure that we continue to join up that planning at the locality level—there is a strength in planning at that level—but also that it joins up with the whole system across the board and links into regional delivery across all aspects of service planning, workforce and resourcing. In Ayrshire, it has been a very positive development.

Monica Lennon: In your joint written submission to the committee, you address the affordability of plans. Again, that does not seem to be an easy task. We understand that boards are required to deliver affordable workforce plans, but you suggest that you have limited information on the future funding that you are going to receive, alongside the Scottish Government requiring you to provide workforce projections for three years. Again, that seems to be quite tricky. How challenging is it on a scale of 1 to 10?

Tim Davison: Ten.

Monica Lennon: It is very tricky.

John Burns: It is very challenging because it is very complex. It is not a linear arithmetic proposition. We are trying to look at so many variables and factors.

When we develop the plans, we have to be clear about what assumptions we have made. We need to understand and bring our best intelligence

to what the environment and the environmental factors are, whether they involve finance or changes to technology. We will have to take some risks in developing the plans because, as we have said a number of times this morning, part of what we need is an adaptable and different set of skills within our workforce, and we need to start to train for some of those. We need to make some carefully considered assumptions, but assumptions nonetheless, if we are to be able to look beyond the one-year horizon, which is very important.

Monica Lennon: Do you have the tools to do that and take that informed approach to risk?

John Burns: It is not new. It is part of what we do. There is no doubt that, as we have heard this morning, some of the developments that come forward around workforce planning tools and data will assist significantly in that process. We have people in our teams and on our boards, albeit that they are small in number, who have an understanding of and expertise in workforce planning. The fact that we have already made some important shifts and changes demonstrates that we can make some of those assumptions, but we perhaps need to be bolder and to look beyond that shorter horizon to some of the longer horizons.

Malcolm Wright: We need to accept the premise of the Auditor General's point that we are not going to be able to significantly increase the NHS and social care workforce numerically, and also the proposition that the training pipeline is very long, particularly for medical staff, so whatever decisions we make today, the world will be completely different by the time people graduate and the time they finish their postgraduate education. We should look at the issue from the point of view that we need a workforce that is adaptable and that can be trained and developed. It is not about producing a practitioner who can do one thing and that is it. We need to produce practitioners who are flexible and adaptable and are able to progress their careers. Partnerships with local universities and colleges of further education are absolutely critical in that regard.

In Grampian, our closest partners are probably North East Scotland College, Robert Gordon University and the University of Aberdeen. We can have discussions with them and project our local workforce requirements and they can do the training. For example, we can get NESCol and the University of Aberdeen to work together to give people who are interested in a nursing degree the confidence and numeracy skills to do it, and then articulate them through Robert Gordon University or the Open University—there are lots of examples of all of that.

Taking the workforce that we have and asking how we can develop it is going to be the key to planning in the future. As well as getting the high-level numbers right, local adaptive action is going to be really important.

John Burns: We have focused a lot this morning on medical and nursing staff. We need to look at the whole workforce, looking beyond health into health and social care and making sure that, as we go forward, those professions and jobs are valued by society for what they bring and offer to communities. We absolutely need to focus on medical and nursing staff, but we also need a much broader focus so that we have a sustainable workforce across the whole system that is there to support those other disciplines.

Monica Lennon: On your point about people feeling valued, I cannot find an exact statistic, but I think that the most recent staff survey—which was for 2015, I think—showed that more than two out of 10 people working in any given health board say that they intend to leave within 12 months. Is that partly due to people not feeling valued? Is it due to lack of morale? What is your understanding of it?

John Burns: Beyond the staff survey, we will all be using the iMatter tool, which gets right down into teams. In Ayrshire, we have had a very positive response to iMatter, with teams looking at their value, how they work in their roles and how they might look to their local team improvement plans. We have had a high level of positive staff engagement on the back of that. That is a much more sensitive tool for working with teams. Of course there will be challenges—staff are busy and will be feeling the demands and pressures on the system—but if we take the right approach to wellbeing and supporting staff, we can help to manage some of the concerns that they rightly express.

Malcolm Wright: I agree with that. The iMatter tool is an evidence-based intervention that has been worked out very carefully. The most recent results for NHS Grampian show a 70 per cent employee-engagement index. That is about how well the employees are engaging with the organisation regarding commitment and involvement against a range of scores. Those scores have been going up over the last three years. Just under 80 per cent of staff say that they have sufficient support to do their job well and that is good, but it also implies that 20 per cent of people say that they do not. Further, we have much lower scores in relation to whether people think that we have enough staff to do the job properly, so there are concerns about the numbers of staff we have.

One of NHS Grampian's major challenges is the supply of a trained workforce, particularly in

nursing. We are doing all the things that we have described with regard to return-to-practice programmes, which have been very successful, and we need to move those efforts much further forward. The thing that makes the difference is the leadership, the engagement and the creation of an environment in which staff feel valued and supported and are really committed to their work. From my point of view, creating that sort of environment is one of my top priorities.

Caroline Lamb: The crucial difference about using the iMatter tool is that it is not just about filling in the survey; it is about then having a conversation with the team and developing an action plan. In boards across Scotland, that is leading to improvements in relation to staff feeling valued and engaged and their ability to have those conversations about what improvements can be made to help them feel even more valued and engaged. That is really important.

Monica Lennon: It is good to get an example of some planning working well.

Can I jump back to my last question on affordability? Colleagues might understand this better than I do, but in your statement you say that, for the medical workforce, boards only have to give a one-year projection. I do not understand the background to that, given that there is a training period of 15 years plus. Can you explain that? It seems a bit odd to me.

Caroline Lamb: It is not just the information that is in boards' workforce plans that is used to look at the number of undergraduate and postgraduate training grades. Over the last couple of years, we have been looking at medical training on a specialty-by-specialty basis. That involves a consideration of the actual profiles within that specialty, what the consultant population currently is and how much we expect that to reduce through retirements over the next few years. It also involves consideration of the training population—that is, how many trainees we are expecting to achieve satisfactory completion of training—and where we have people going out of training, for maternity leave for example, so that we can factor in that information. There is a quite complex mechanism that looks at what medical training we need in each specialty. That is somewhat informed by boards' workforce plans, but much more sophisticated profiling goes on behind that.

10:45

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): Good morning. I would like to continue the discussion on service redesign and give you an opportunity to summarise and give us your thoughts on it, but first I want to jump back briefly to the university admission issue that Alex Neil raised.

The information that we have in front of us for the universities does not give us any information from the medical schools at the University of St Andrews or the University of Dundee. Our papers say that that information is not publicly available from those two institutions. Is there an explanation for that? The reason I ask is that, when I was on the Equal Opportunities Committee, we covered the issue of university admissions to medical schools from across the population. Why do we not have data from them, and can we get it?

Caroline Lamb: That is a question for the universities. They decide what information they make publicly available, and it would be up to the committee to ask them to provide that data.

Willie Coffey: As I understood it during my time on the Equal Opportunities Committee, they gave a commitment to supply that.

Tim Davison mentioned that we are becoming more successful at getting undergraduates from across the population sectors to go to medical school. That was a key concern for that committee at that time. Is that borne out? Is that beginning to bear fruit?

Tim Davison: As you know, the University of Edinburgh is represented on our board—the head of the medical school is one of our non-executive directors. We have an extremely close relationship with the university and we were talking with representatives of it as recently as yesterday evening. The particular thing that I referred to was a briefing from the dean, who said that the proportion of Scottish school pupils from the two most disadvantaged quintiles who received an offer from the university was 33 per cent, which amounts to 30 applicants. I believe that that is a step in the right direction. The point that I was making is that we need to increase that.

Another issue is that some universities do not interview applicants; instead, they use entirely paper-based and academic-qualification led criteria for appointment. The point that I was trying to make earlier, perhaps clumsily, is that I want to encourage universities to interview candidates for university to see if they have the aptitude to do the job that we require them to do. We require them to work 24/7 rotas, even if they are working part-time and less intensively. We require them to fill GP roles. We require them to work in rural and remote areas in Scotland. The two things go hand in glove because, if we broaden the scope of applicants, that would include broadening the scope to rural and remote areas. My hunch—it is just a hunch—is that, just as we believe that Scottish-domiciled students are more likely to remain in Scotland, it is possible that remote and rural-domiciled

applicants would perhaps be more willing to go back to work in remote and rural areas. We are beginning to see a bit of movement in that regard. To be fair to the University of Edinburgh, there is an appetite to get into those issues now, in the way that Edinburgh is demonstrating, and I am sure the other universities are doing the same things.

Willie Coffey: That is encouraging.

I believe that Caroline Lamb said that the limitation in intake numbers is set by Government. Has that changed over recent years, given the fact that we know that GPs see their own futures as perhaps involving more short-time or part-time working, lifestyle changes and different demands? Are we reflecting our intake numbers based on that kind of performance from GPs?

Caroline Lamb: The intake to undergraduate medical schools was increased by 50, I think for 2016 onwards. The Scottish Government is establishing a Scottish graduate-entry medical school, which will have its first intake in 2018. The Scottish Government has also announced that there will be additional places focused on trying to retain more graduates in Scotland and also on attracting more people into GP training, again from 2018. We are seeing an expansion in undergraduate numbers.

Willie Coffey: I will turn to the service redesign issue, and I will try to be very positive. Scotland's NHS is probably the best-performing health service in the UK. Patient satisfaction is the highest that it has ever been. There is record investment. There are nearly 3,000 more GPs than there were 10 years ago. However, is the public perception—perhaps their expectation and their demand—beginning to outstrip our ability to deliver what is a really good service to the public? In the broad context of service redesign, what are the key messages that you could give to us and to the public who may be listening to this discussion? What kind of changes do we need to make? If, as Liam Kerr says, we consider this issue again next year, or even in five years, what would we expect to see with regard our ability to begin to manage the public's expectations of the NHS?

Tim Davison: The biggest single thing is about reducing demand, and there are various measures that can help with that.

Our population is growing, our older population is growing, people are living long enough now to live with multiple longer-term conditions, all of which require medication, care and intervention and so on—people are now living long enough to get cancer and then live with cancer for a long period because of advances in care and technology. At the same time, our working-age population is reducing, which means that the workforce supply is not going to keep pace, and the money is looking pretty flat. The traditional response over the past 20 years has been to throw more and more money at the health service and employ more and more staff to do things increasingly faster—waiting times used to be a maximum of 12 months; then a maximum of 26 weeks; then a maximum of 18 weeks; and now they are a maximum of 12 weeks. However, there is a limit to how long that approach can continue. The traditional response of responding to growing demand in the health service by using more cash and more staff is just not an option. Therefore, our endeavours have to be focused on shifting demand.

The sorts of things that we are doing, which are coherent, involve, for example, not making unnecessary interventions that do not add value. There is a lot of work around that. The realistic medicine scenario is important. It involves offering procedures not simply because we can but only when they will actually lead to an improvement in the patient's condition. There are issues around demand for new medicines in cases in which the cost of a new medicine vastly outstrips the very marginal population health improvement that will result from its use. There is the issue of the approach that means that people currently have to go to a GP in order to be referred to a podiatrist rather than just going straight to a podiatrist and so on. Earlier, I mentioned self-management of conditions, which might involve people using digital technology or artificial intelligence-equipped technology to help them—everyone knows the Google doctor who will help them with their condition. Further, people could use a community pharmacy rather going to the GP to go on a waiting list for an outpatient referral and so on.

My personal view is that the new focus for us all—politicians, service providers, patients, carers and so on—is how we manage down the demand on the health service.

John Burns: I agree with what Tim Davison has said. We need to think carefully about how we are going to support citizens differently in their homes and how we support individuals with long-term conditions.

Technologically, there is a lot more that we can do. We have some great examples, but they are on a small scale and we need to think about how we can scale them up. We also need to make sure that citizens are confident about using technology in the way that tests have shown can work successfully. Indeed, we have seen examples in Ayrshire—I am sure that colleagues will have examples in their areas—of that enhancing the quality of an individual's life. They are not having to go to hospital three, four, five or six times for appointments because they are able to self-

manage. They are able to work and look after their own health more effectively because of anticipated care planning and knowing what to do if they have an exacerbation of a condition. Technology is important.

The chief medical officer has started an important conversation about realistic medicine and the need to engage differently with clinicians and patients, which I believe will have an important part to play. However, at the heart of what we have to do is the dialogue that we must have with our communities about how these are positive changes that will add benefit and bring quality of life to the individual by enabling them to use new technologies so that they do not need to turn up at hospital or their GP practice often.

My final point is about the wider community being seen at the right time by the right people, who are not always the people we might traditionally think that we need to see. In Ayrshire, we have been doing some fairly good work around eye-care services whereby we have been redirecting people from hospital and general practices to the high street optical services with great success. Initiatives such as that are what we should see at the heart of redesign.

Willie Coffey: Malcolm, could I hear your views?

Malcolm Wright: We hope to see a significant shift from acute hospital care to care in communities and in primary community care settings. John Burns talked about realistic medicine, which is about changing the conversation that clinicians have with patients. The fact that something can be done does not mean that it is the best thing to do. We should be helping people to have a full understanding of what their condition is and what the choices for them are. With that better dialogue, they might just make different choices.

We can use technology to develop local community capacity. For example, if someone lives in a remote community on one of the islands and they need to see a consultant for an out-patient appointment, there may need to be a certain amount of travel and an overnight stay. Could we use the Attend Anywhere software that NHS 24 has developed to enable the patient, if they do not need hands-on care or if it is a return out-patient appointment, to attend the appointment in their local community?

I think that, in the future, we are going to see much more of a shift to care in local communities, more community resilience and a multi-professional team of different practitioners working within a community to support people with slightly different expectations of what their care pathways are going to be.

Caroline Lamb: The final point to make is that we need to focus on prevention more broadly than just within NHS Scotland. It is an issue for the whole public sector and, indeed, Scottish society.

Willie Coffey: Can I share an example with you? This week, in preparation for the meeting, I visited one of my local practices. The lead practitioner told me that the practice has 2,000 visits a week and 13,000 patients on its books. That means that everybody comes to see their GP seven or eight times a year. That is not sustainable, and that huge volume of repeat visits is one of the main reasons why a lot of GPs feel so stressed and pressured. The patients really value the service, but I suggest to you and colleagues that we cannot sustain that number of visits; therefore, we must take patients on the journey with us and reach out to them—it is a partnership. The health service is held in high regard by them, but their expectations are huge and are perhaps going beyond what it has the ability deal with.

How do we reach out to those 13,000 or so patients to say to them, “There are different options. It is not a failure if you do not see your GP at their practice”? Many of them think that it is. They say, “I want to see my GP or else”—there is still such an attitude—but there are now many specialisms in GP practices. Have we failed to persuade the public that there is a better model for their healthcare? At the minute, I do not think that they feel that. They feel that it is a failing if they cannot see the person they want to see on a particular day.

11:00

John Burns: That is right. We need to do more to communicate that the changes are being made for positive reasons. I have given the example of eye care in Ayrshire whereby, instead of going to see their GP, people can go and see the optician in the high street. We have seen that shift in behaviour among people who are using those services in Ayrshire. As a pilot scheme, it has evolved very successfully but we need to be more explicit. Our communication needs to be better and we need to be clear about why we are telling people to do that. We are not saying, “Do not go and see your GP,” but, “It would be better if you went to see this other practitioner.” If someone is referred to a nurse, a physiotherapist or another professional, it is because we believe that they are the right person to support them in their care needs. We are not saying that people should not see a GP; it is about not making that the default position. We need to engage more effectively with our communities, and perhaps, on a wider Scotland basis, we need to think about sending some key messages about how our communities

can work with us. I agree that there has to be a partnership.

Willie Coffey: Communication is fundamental. I am sure that other members of the committee have had many engagements with constituents who do not really get the language that the NHS might use in writing and communicating with them. There is a degree of suspicion about what they read. They think, "Oh, they are trying to pass me off to this or that." That is the kind of perception that we need to improve in order to embrace direct engagement with patients. They need to understand that it is a better journey for them, that it is a whole healthcare model that we are looking at for them and that we are not just pushing them out of the door because we are too busy or overstretched. We have a lot to do in that area, and I would appreciate it if you would take that message on board to see whether we can improve the situation.

Malcolm Wright: I very much agree with that. That is something on which local systems and central Government can work hand in glove. A number of years ago, in winter planning, we started a know who to turn to campaign whereby we said to the public, "These are the different types of practitioners. If you have got this condition, it is maybe better to go to a pharmacist," or, "This is what an optician can do. This is what a dentist can do." Modern dentists, optometrists and pharmacists have the training to pick up things that might not have been picked up 10 years ago. We must get the message over that it is not just about the GP. GPs bring a unique set of skills, but there is a range of professionals that people can go to. Messaging and narrative from the Government to support that would be really helpful.

Willie Coffey: I do not know what the European experience is, but do you get the impression that citizens in other jurisdictions are already moving around the health service and finding those different skills, or are they relying on the traditional one-to-one relationship with their GP? Are things moving on in other jurisdictions? Do we need to catch up a wee bit?

Tim Davison: There are many different models. Some citizens of European countries go directly to secondary care—directly to specialties—and do not touch base with a GP. That is a fundamentally different system. In New Zealand, which, in many ways, has a similar demography to that of Scotland, citizens have to pay about £30 to see a GP, which obviously has an implication when they are thinking about what they want to do. There are different models. Part of the reason that we have not yet got the plan that is going to deliver all this is that it fundamentally requires buy-in not just from citizens but also from our staff—and not just from our current staff but from our projected staff.

In Edinburgh, we have a practice in a very deprived area where, a few years ago, the GPs were simply overwhelmed by the demand. There was a huge young population with a lot of substance and alcohol misuse problems, which was quite a chaotic population for the GPs to deal with. They were so overwhelmed that they could not offer appointments within a week or 10 days. The local GPs introduced a telephone triage system that told people that they could not just phone up and ask for an appointment but that they had to have a telephone conversation with a GP—latterly it was often not a GP but, initially, it was a GP—about what they wanted to come in for, telling them a bit about what they wanted to know.

That system was really good, because it could signpost a person to deal with their issue through a repeat prescription if they did not need to come in and see a GP for it—the GP could ask the pharmacist to deal with it. If the person had a musculoskeletal issue, they were told that they should be seen by a physiotherapist quickly—the GP could organise that, and it did not require the person to come in and see them. When someone had a major problem that was really complex, the GP could say, "Okay, I will see you, but I am going to give you a 20-minute appointment rather than a five-minute appointment."

The system transformed the ability of the practice to respond. On the day that I visited the practice to chat to the GPs about it, they showed me their appointment book and there were still appointments vacant for that very day. However, when members of that practice stood up in front of representatives of 130 practices across Midlothian to describe their approach, quite a few GPs said that they did not like that approach because they thought that primary care was all about an interpersonal, long-term, face-to-face relationship with their patients.

As leaders, we have a big job in trying to rapidly implement what appears to me, as a health service manager, to be a fantastic solution that is patient centred in the way that it has been described but that is a model that quite a lot of other practitioners do not like.

You asked how big the challenge is. I think that it is a 10. That is not to say that it cannot be met, but I do not think that we should underestimate how tough that is going to be. There are many stakeholders that we have to align in order to implement a different way of responding to traditional demand.

Willie Coffey: Absolutely. What was the patient response to that new model?

Tim Davison: It was fantastic.

Willie Coffey: That is very interesting. Thank you.

The Deputy Convener: Thank you for pointing out that model.

We are getting pressed for time, so we need quick questions and quick answers, if you do not mind.

Bill Bowman (North East Scotland) (Con): Thank you, convener. Everything that I have heard this morning from our colleagues has been most interesting. Let me take a slightly different approach. You have put together a giant submission. Can I deconstruct that a little bit and ask you individually, as senior executives of your boards, what you are doing well in workforce planning that others might benefit from or be interested to hear about?

John Burns: I will start. There are a number of things in NHS Ayrshire and Arran that I would highlight; some have been referenced. We have reporting radiographers and we are looking to develop that beyond plain film reporting, and we are considering extending the roles of biomedical scientists in pathology.

The work that we have done over many years in respect of advanced nurse practitioners and the scale and range of activities that they are now involved in is something that we see positively. For example, the out-of-hours service on Cumbrae that we talked about earlier is very successfully delivered by advanced nurse practitioners.

In communities, we are seeing some good developments around using other skills in the eye care service, which I have referred to, and we have brought in physiotherapists and pharmacists to the multidisciplinary teams.

Bill Bowman: When you mentioned "eye care", I thought you were talking about "iCare"—everything these days is iThis and iThat—which would be a new system for people looking after themselves. [*Laughter*.]

John Burns: I apologise.

Tim Davison: To be brief, I will give one example, which combines technology, regional collaboration and a bit of innovation. A board in the region could not recruit radiologists, so the reporting times for its film, magnetic resonance imaging, computed tomography and so on were extremely challenging. We therefore created a single radiology reporting system with a single technological base that would allow an image that had been taken anywhere in the region to be reported on by a radiologist anywhere in the region; an image that had been taken in Fife could be reported on in the Borders, and an image that had been taken in Edinburgh could be reported on in Fife. That has allowed us to respond to a workforce challenge through regional collaboration added to digital technology.

Bill Bowman: Is that happening elsewhere?

Tim Davison: I was giving you an example of what we have done well.

Bill Bowman: I was looking for something that others could learn from.

Caroline Lamb: I am in a slightly different position because NES is a national board and supporting other boards is part of our raison d'être. However, if I am going to pull out one thing, it will be what we have done over the past few years on improving our digital capacity and capability. That is why we want to develop the platform. The whole point is to ensure that information about the workforce is available on a once-for-Scotland basis to whoever needs it for planning, and thereby to improve the planning process.

Malcolm Wright: I would support that. What Caroline Lamb has done in terms of the Turas system and supporting boards with education and training is absolutely spot on.

I will give two or three quick examples. The first is the development of clinical development fellows' roles in order to plug gaps, by giving doctors who want to step out of their formal training programme for a time some experience before they get back on to the training ladder. I have mentioned physician associates and advanced practitioners.

Something that has really struck me in NHS Grampian over the past two or three years has been the quality of medical and nursing AHP leadership, and teams working through issues together. We have also seen lots of redesign work going on in our surgical services in our operating theatres, which has progressed at a rate such as I have never seen before.

In Aberdeenshire and in Moray, there has been a development called the virtual ward. It is led by GPs, who meet the practice team every morning to think about the range of patients who might trip into a hospital admission, and consider whether they could send a district nurse, health visitor or whoever to patients who are at risk or vulnerable, or make some intervention and support the patient in their home in order to avoid their tripping into a hospital admission. That example has been developed right across Aberdeenshire and into parts of Moray.

Finally, I believe that the collaborative work on delayed discharges has made a huge difference to the lives of many patients, and to the running of Aberdeen royal infirmary.

Monica Lennon: My question is a supplementary to Willie Coffey's line of questioning. He touched on how to reduce

demand and have fewer people going to the surgery. The other side of the coin, which concerns me, is the people who do not access services and who do not get to the doctor, the pharmacist or the nurse. I am thinking about Lanarkshire, where I am based. Tim Davison touched on substance misuse, alcohol and drugs services; I am thinking about the reduction in such services and about the people who do not get help quickly enough, which increases demands on the NHS further down the line. If we are going to see a continuation, particularly at local council level, of services being cut back, will that store up troubles for the future? How can we get the people who are hard to reach into services more quickly?

Tim Davison: That will store up problems for the future: it is a major problem. We talk about prevention, but we also talk about the demand for improving treatment. The reality is that the pressure on social care budgets has meant that people now really need to be in critical need of a service before they get a social care service, as opposed to their getting it earlier, when prevention would help. There is broad acknowledgement that that is the case. I will go back to what I was saying earlier: we need macroeconomic choices to be made. If all the available money is poured into elective waiting times, it is not available for primary care. If all the money is put into increasing staff numbers, it is not available for new drugs and so on.

The numbers simply do not add up, at the minute, so we must have short-term, medium-term and long-term planning. Austerity has been around for 10 years. I have been in the health service for 34 years: I have worked under every shade of Government, and I have worked in times of plenty and times of great difficulty. I have learned from that that things get better eventually. We are saying that the financial outlook for the next three or four years is really bleak—that is the reality—so if you hear one thing from us, it will be that we acknowledge that short-termism in workforce planning has not helped. We need to raise our gaze and to plan beyond austerity. Whether the solutions are at UK level, at Scottish Parliament level or whatever, a growing population with growing health needs will cost more money, and that needs to be addressed fundamentally.

11:15

The Deputy Convener: I will be brief. We will hear next week from Paul Gray, who currently has a dual role as NHS Scotland's chief executive and as a director general in the Scottish Government. I am interested to know how that works in practice. In his capacity as NHS chief executive, what is his relationship with the boards' chief executives? Is he directive? Is he consensual? How does it work?

Malcolm Wright: The relationship is relatively close. We meet Paul Gray and his directors formally monthly. There is a lot of conversation and dialogue, and he is very clear with us about the policy of the Government, about where the service is heading and about what the priorities are. We have those conversations.

One of the great things about working in Scotland is that people in positions such as ours can have conversations with ministers and with senior government officials, so we know where things are heading. It is challenging at times—in our conversations with Paul Gray we are very clear about the challenges that we face, and he is very clear with us about the priorities of the Government—but I believe that it is a useful and constructive conversation.

The Deputy Convener: Thank you. On that note, if there are no further questions, we conclude our evidence session. I thank the witnesses very much for their evidence.

11:16

Meeting continued in private until 11:27.

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