OFFICIAL REPORT
AITHISG OIFIGEIL

Public Audit and Post-legislative Scrutiny Committee

Thursday 20 December 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 20 December 2018

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PUBLIC AUDIT AND POST-LEGISLATIVE SCRUTINY COMMITTEE

30th Meeting 2018, Session 5

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)
Alex Neil (Airdrie and Shotts) (SNP)
*Anas Sarwar (Glasgow) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

John Burns (NHS Ayrshire and Arran)
Dr Catherine Calderwood (Scottish Government)
Angela Constance (Almond Valley) (SNP) (Committee Substitute)
Paul Gray (Scottish Government and NHS Scotland)
Christine McLaughlin (Scottish Government)
Professor Elaine Mead (NHS Highland)
Shirley Rogers (Scottish Government)

CLERK TO THE COMMITTEE

Lucy Scharbert

LOCATION

The Adam Smith Room (CR5)

Scottish Parliament

Public Audit and Post-legislative Scrutiny Committee

Thursday 20 December 2018

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Jenny Marra): Good morning and welcome to the 30th and final meeting in 2018 of the Public Audit and Post-legislative Scrutiny Committee.

I welcome Angela Constance to the meeting; she is attending in place of Alex Neil, who sends his apologies. I ask everyone in the public gallery to please switch off their electronic devices or turn them to silent.

Do members agree to take items 4, 5 and 6 in private?

Members *indicated agreement.*

Section 22 Reports

"The 2017/18 audit of NHS Highland: Financial sustainability"

"The 2017/18 audit of NHS Ayrshire and Arran: Financial sustainability"

09:00

The Convener: Item 2 is on the section 22 reports "The 2017/18 audit of NHS Highland: Financial sustainability" and "The 2017/18 audit of NHS Ayrshire and Arran: Financial sustainability". I welcome our witnesses to the meeting. John Burns is the chief executive of NHS Ayrshire and Arran and Professor Elaine Mead is chief executive of NHS Highland. Both will make opening statements.

Professor Elaine Mead (NHS Highland): Thank you for inviting me here today to give evidence to the committee regarding "The 2017/18 audit of NHS Highland: Financial sustainability".

As you are aware, NHS Highland is currently not financially stable, and I would like to take a few moments to outline the reasons for that position. There is an increasing challenge in balancing the three areas outlined by the Auditor General, namely finance, waiting times and the quality of care.

In NHS Highland, we have continued to ensure that there is a clear focus on the quality and safety of care—including adult social care—through our Highland quality approach, while maintaining key waiting times for patients, which has been to the detriment of our ability to maintain financial balance in 2017-18.

There are significant challenges that are specific to the delivery of care in remote and rural areas and island populations that, without doubt, are complex and more costly due to the significant distances. Covering 41 per cent of the most remote and rural geography of Scotland, with an ageing population, it has been more challenging every year for NHS Highland to sustain the historical models of care within budget, due in part to our inability to recruit key members of staff.

Our focus has been on ensuring that we can provide an appropriate and timely response to keep people safe, both in and out of hours, but that has come at a significant cost.

As a board, we are committed to the reduction of waste in the system and the transformation of services to ensure that we have sustainable and integrated care, fit for future generations, for the people of the Highlands.

In order to do that, we must change. Such change inevitably takes time, but we have already embarked on that journey, and I thank our outstanding staff for their continued efforts. I will be very happy to do my best to answer questions from the committee. Thank you, convener.

John Burns (NHS Ayrshire and Arran): The 2017-18 audit of NHS Ayrshire and Arran set out in its summary that we need to address both efficiency and transformation to tackle the challenges that we face in NHS Ayrshire and Arran. In our submission to the committee for this evidence session, we have set out our approach to looking at that throughout the system in Ayrshire and Arran, across integrated health and care planning.

Our 10-year strategy is called caring for Ayrshire. The plan will be delivered through our transformation programme, which will underpin the reform that we believe is needed to our model of care. We will strive to deliver the right care in the right place, in a system that has the right balance between acute service provision and community provision.

As well as the transformation programme, we recognise—as the audit report set out—that we need to have a strong operational grip on our day-to-day management and, in doing that, we need to ensure that we provide our services at best value and with the right safety and quality.

This is a significant programme of work that we are undertaking. To ensure focus, we have established a robust operational governance and programme management arrangement. We have a delivery plan in development for the next three years that will address our performance, service delivery, service change and service redesign. We will bring together the impacts on workforce and infrastructure and pull all that through into the three-year revenue plan.

I believe that the work that we are doing is building a strong foundation for that three-year plan. I want to reflect the hard work of the teams across Ayrshire and Arran in committing to the work that we require to do. Our partners will play an important part in delivering the reform that we need in Ayrshire and Arran.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I have a question for NHS Ayrshire and Arran. Your submission describes the effective prescribing programme and the improvements that your respiratory prescribing-to-care work has brought about in the short term. What are the clear long-term outcomes against which that initiative will be measured?

John Burns: The programme looks at the end-to-end pathway for respiratory care. Within that, we have looked at the impact of prescribing.

Ayrshire and Arran was in benchmark 1 for the higher-cost prescribers in respiratory medicines. We have taken the view that the best way to change is to look, with our clinical teams, at how we transform and deliver services differently.

On the respiratory pathway, we focused specifically on how we effect change to prescribing, particularly around inhalers, and on how we can move some money into community-based pulmonary rehab and specialist nursing—moving some reinvestment from prescribing to other services that are evidenced to be highly effective.

Colin Beattie: You highlighted that the cost seems to be highest in relation to steroid inhalers. How do you reduce the use of those given that, presumably, people are dependent on them?

John Burns: We have worked with our respiratory team, primary care teams, pharmacists and others to look at the care pathway and at where medicines can effectively and properly be used. Within that, we have recognised that by investing in areas such as pulmonary rehabilitation and specialist nurses, we can provide support for patients that improves and enhances their quality of life while at the same time reducing the level of and spend on prescribing and moving some of that money to investment in areas where there is evidence of a positive impact. The early indications from our work are that patients like it, that it has reduced the number of unscheduled care admissions to hospital and that it has reduced the length of stay for those who need to be admitted. It has had a very positive impact on outcomes for patients.

Colin Beattie: Has there been any negative impact?

John Burns: No.

Colin Beattie: The NHS Highland submission talks about redesigning models of care and so forth. It states:

> "These new models will be more sustainable but they have proven to be very difficult to consult and agree. Even where there has been consensus, through public consultation, decisions have come under constant public and political challenges. Not surprisingly the pace of change has been very slow."

Will you give examples of public and political challenges that you have encountered?

Professor Mead: Yes, indeed. We continue to consult on any changes that we would like to make. Clearly, a number of those services are very precious to local people. Skye may be an example of a place in which we looked at how we could reconfigure out-of-hours services to give us the best possible value to meet people's needs. As I said in my introduction, the important thing for

us is to ensure that services are safe for them. As we looked at the services on Skye and redesigned them, we found that local populations had not felt safe. They said that they were concerned about any reduction in the level of care that was being provided.

However, there is a significant cost to how we provide out-of-hours services. For example, in Wester Ross, out-of-hours costs per case could be as high as £1,400, whereas in an Inverness practice they could be just £70. Therefore while the process must be driven by access and safety, there is a cost element. We need to ensure that we can provide the best care for people 24/7.

The opposition that we have had is because people do not always understand about emergency care and feel that the out-of-hours care, which is provided mostly as primary care by general practitioners, is the same as emergency care, which is a 999 response. We need to communicate better and to engage much more with politicians and local people to make absolutely sure that they understand that changing the out-of-hours service does not have an impact on the emergency care services that we provide for them.

Colin Beattie: In the example that you gave about Skye, has there been a public kickback against the proposals for change?

Professor Mead: Indeed, and we have involved local people and politicians and have had Sir Lewis Ritchie join us in that work. We are making progress now, but there is an additional cost to any of the changes that we have wanted to make.

Colin Beattie: You have mentioned political challenges as well as those from the public. What political challenges have you had?

Professor Mead: We have had them at all levels—at local level, for local members providing support to their constituents, but also party members bringing forward the concerns of their local constituents. That is understandable, as people right across our patch are concerned about changes that we are attempting to make.

Most recently, in Caithness, we have had a wide-ranging public consultation over a number of years. Local politicians and the public have asked us why we need to make changes. Our reason is that the existing models of care are simply not sustainable in their current form.

Colin Beattie: In my experience, if you are suggesting fairly radical changes the first thing to do is to brief local politicians fully, so that they understand the reasons behind them and can get behind the whole process. From what you are saying, that does not seem to have happened here.

Professor Mead: We could have done better, but we have made every attempt to meet local politicians regularly and to brief them. We now have the full support of all members of the local authority in Caithness, on which a motion was passed last week. It takes time to have conversations, share the evidence and help people to understand all parts of the jigsaw in a local area that lead us to need to make a change. Time is the issue for us. We need to spend a lot of time explaining the need for change and why the current models of care are no longer sustainable.

Colin Beattie: Do you think that the current type and level of communication that you have with the public and with politicians are adequate?

Professor Mead: We can always do better. We always reflect on how we are engaging. We meet our MSP and MP colleagues regularly, but we also meet our colleagues from both Highland Council and Argyll and Bute Council.

Colin Beattie: Obviously, your changes have to be open to public scrutiny.

Professor Mead: Indeed.

Colin Beattie: Is it worth revisiting how you are approaching the process? From what you are saying, the whole project and the models are being slowed down. If everything is meeting public and political challenge, clearly you will not achieve your targets within a reasonable time.

Professor Mead: No, and that is the difficulty that many boards face, but particularly in our own region, where we need to change the models in remote and rural areas.

We need to make changes across our whole patch, from Campbeltown to Wick, and we need to engage with the communities in all those areas. However, it would take us two and a half hours to drive just to have a conversation with someone in Wick, for example. It might be timely to do that, but it takes a huge amount of the local team's time to continually engage in that way. However, we understand and accept that we cannot make changes without engagement, and we will continue to do our best to engage with local people.

09:15

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): My questions are for John Burns of NHS Ayrshire and Arran. Good morning, John. First, I echo your comments in paying tribute to the great work that the staff throughout NHS Ayrshire and Arran are doing, particularly in Crosshouse, which I know very well.

The Auditor General has written some fairly detailed reports on NHS Ayrshire and Arran over

recent years, principally regarding concerns about its overspend and brokerage. She has also highlighted a lack of attention to detailed financial planning and the consequent impact of that on performance. Ultimately, she finds it difficult to see how the board can achieve financial balance in the coming years. How do you respond to those findings?

John Burns: We started this journey in 2016-17, when we recognised that we needed to do more than just deliver an efficiency programme, as I referred to in my opening statement. We have been developing a new approach to deliver transformational change while delivering the operational grip that is necessary. In the past 18 months, we have made significant changes to our approach. We have a much tighter operational scrutiny programme and very detailed programme management through which every programme and efficiency is tracked and reviewed regularly for progress and delivery. We have introduced clear accountability for each programme and we are now seeing the change deliver. We review matters in-year through a financial control schedule, so that we are clear about how we are delivering what we are delivering and, if something is not delivering, what scrutiny and interventions we need to make. I believe that we have moved on significantly, and we have a strong position on which we continue to build.

Willie Coffey: Is there anything that is peculiar when it comes to NHS Ayrshire and Arran? It has been widely reported that you have overspent significantly. I, for one, have said in this committee that you are spending money on healthcare needs that people in the population actually have. There is an argument and discussion to be had there. What is your view? Does the funding formula correctly reflect the health needs of the Ayrshire and Arran population, or should thought be applied to adjusting and revisiting that to award fairly what NHS Ayrshire and Arran needs in order to deliver that healthcare?

John Burns: We recognise that the funding formula is the same for all NHS boards, so we need to work within that formula. However, we have also recognised that we need to change the balance in our health and care system in Ayrshire and Arran. There has been an overreliance on acute hospitals. Together with our health and social care partnerships, we are looking to develop the right balance. For example, we have recently made a significant investment in intermediate care and community rehabilitation across all three partnerships to support patients coming out of hospital and, where patients do not need to be admitted, to provide additional support for them in the community. We believe that there is a strong evidence base for that work, and that it is already bringing change in the use of unscheduled care beds.

We are seeing quite a lot of change and transformation, but we recognise that we have some real challenges in terms of our population's health across Ayrshire and Arran. Again, we are looking to ensure that we provide our services in a way that supports patients to take ownership of their health and wellbeing, where that is appropriate, and to use technology, including digital technology, to provide some of that. Where it works—it is in its very early stages but it works well—we need to scale that up. We need to continue to look at the reform agenda in NHS Ayrshire and Arran in order to get the right balance.

Willie Coffey: You mentioned a couple of areas, such as unfunded beds, but what are the key areas that will help you to get control of the finances in the coming years? Is it workforce? Is it prescribing? Is it agency staffing? Is it all those things? How are you making progress in turning it round?

John Burns: It is all those factors. We are making good progress on prescribing. Our primary care teams are doing excellent work on prescribing, and this year we will exceed our target. We set an ambitious target for hospital prescribing changes and, based on current forecasts, we will slightly exceed it.

There is no doubt that workforce is a challenge, and we are clear that we need to be a board that can attract and retain staff, particularly medical staff, in areas where skills are scarce. We have a record of being able to recruit staff, but there are some hard-to-fill posts, which necessitates spend on locum doctors in order to maintain services. We need to continue to look at how we redesign our services to make them sustainable, because if we cannot get the medical workforce, we need to look at the workforce model that supports that service.

We also need to look regionally at how we work with our colleagues for some of those solutions. As you know, we already have examples of where that works well, where Ayrshire partners with other boards and the pathway back to Ayrshire is effective.

Willie Coffey: I know that you rely on working with partners in the integration joint boards in North Ayrshire, East Ayrshire and South Ayrshire. Presumably, they all run at different paces. What factors do you rely on that are outwith your control but impact on delivering the successful transformation strategy that we seek?

John Burns: We can manage much of it in the health and care system, and the strength of our partnership is important there. You are right to say that the three boards are different and work at

different paces, but we work well together. As we look forwards, the biggest change, which Elaine Mead referred to in her earlier responses, is about ensuring that we have the right communication about change with our communities. As she highlighted, we are looking to work and engage with communities about the need for change, why it is important and what it will give our communities, not what it will take away, in terms of having sustainable services with expertise when it is needed.

The Convener: Forgive me, Mr Burns, but communication is in your control. Mr Coffey asked you what factors are not in your control.

John Burns: There are factors that are not in our control. If we cannot get the workforce, that is not something that we have direct control over. We work with NHS Education for Scotland on training for posts, but we need to work with our communities. I absolutely accept that communication is in our control, but the ability to influence and impact change sometimes requires that control to be shared with our communities, so that it is not just us who are moving forward, but all of us together.

Willie Coffey: What I meant, convener, is that the pace of change on health and social care is different in the three council areas, so the health board does not really have full control over discharges from Crosshouse hospital. It works well with partners but, as I understand from previous discussions, the pace differs. How can we help move that along a bit faster, so that all three councils operate at the same pace in a system that, we hope, will successfully fulfil the health and social care integration agenda?

John Burns: All three Ayrshire councils are working on that. We recognise that they are in different places, and some of that is because their reform in social care is at different places. One thing that we should and could encourage is the sharing of best practice across health and social care systems.

Willie Coffey: You project an additional overspend of £30 million for 2019-20, but we know from the budget that you have been allocated an extra £25 million. Can you assure the committee that you will balance the budget? In prior papers, you have stated that you will, but are you confident that you can achieve that in the immediate coming years?

John Burns: I am confident that we are doing everything possible to achieve that, and it is absolutely our intent. The cabinet secretary's position is that we should plan our revenue over a three-year period, hence the three-year plan that we are developing. We are clear that we need to deliver a balanced budget.

Liam Kerr (North East Scotland) (Con): None of the issues that we are hearing about is unique or new. Why did the planning for transformation not start earlier? Did the Scottish Government not pick up any of the issues coming down the line through monitoring?

John Burns: As I said, we recognised in 2016-17 that the level and pace of change in Ayrshire and Arran were not sufficient and that we needed to look more widely at transformation. We were seeing financial pressures at that point. We had been able to balance our books and deliver efficiencies over many years, but 2016-17 was the first year when we saw that difficulty. At that point, we started our work to develop the programme that we have today.

Anas Sarwar (Glasgow) (Lab): I will come on to the workforce challenges in a second, but I want to pick up from where Colin Beattie left off. Professor Mead, you said that the current model of care is "not sustainable". We all probably agree with that, but is it because of budgetary pressures and the need to make efficiency savings and cuts, because we have workforce pressures and simply do not have the staff to deliver the service sustainably, or because there have been so many advances in medicine and medical technology that it is simply not right to keep the model as it is? Which one of those three is it?

Professor Mead: I believe that it is all three. That is the combination that we are all challenged by and are here to celebrate. There has been such fantastic innovation and progress in medical technologies over the years. We are keeping people alive for longer, and therefore their requirements and needs are more extensive. We have innovation, new technology and new drugs. Just in NHS Highland, we have had a 35 per cent increase in the cost of hospital acute drugs in the past five years. We need to give those drugs to our patients.

Anas Sarwar: Taking the example of Skye, if you had the budget and the GPs, would you still want to reduce out-of-hours services on Skye?

Professor Mead: We would always want to look at best value and make absolutely sure that we have the right model. We are not looking to change the models because of money; actually, we are not able to recruit the GPs. Particularly in Highland, which is maybe a barometer of some of the changes in the rest of Scotland, we see most acutely the pressures due to the inability to recruit staff. There is a need to make the public understand that we cannot have everything in the way that we have always had it. We want to be able to reconfigure things that are really not best value and not necessary while maintaining safe services. We will never compromise on safety in our services.

Anas Sarwar: Just to clarify, are you saying that, if there were adequate numbers of GPs and adequate funding, there would not be a reduction in out-of-hours services on Skye?

Professor Mead: We would still want to have a conversation about whether that model is the right one for the resources that we have available. We have pressures across the system, as a result of things such as innovations and the cost of drugs. For example, in our radiology services, we have had a 55 per cent increase in the requirement for imaging through computerised tomography and magnetic resonance imaging. All those things add up to additional cost. We need to consider whether we wish to continue to invest in things, whether we are getting best value and the needs of the local community. We need to have that conversation more widely with the public to understand exactly what the needs are.

09:30

Anas Sarwar: Is there a huge vacancy rate for radiologist and radiographer positions?

Professor Mead: Yes, it is huge.

Anas Sarwar: That will be a huge challenge across the country.

Professor Mead: It is a major problem. In total, NHS Highland has 36 consultant vacancies; 13 per cent of all consultant positions are vacant. All those positions need to be covered. That will cost us £15 million in locums while we continue to provide the same models of care. For a number of years, we have been looking to change those models—all boards are doing that.

Anas Sarwar: What proportion of your consultant vacancies are you advertising as 8:2 contracts or 9:1 contracts? What impact is that having on recruitment?

Professor Mead: We are now very flexible with contracts for colleagues, and we allow conversations. We are not just looking to recruit to individual posts; we want families and partners to join us. We are doing everything that we possibly can. The difficulties in recruitment are not because NHS Highland is not a fantastic place to work and practise. As you have outlined, there are simply not enough consultants in many specialties.

Anas Sarwar: Is the situation the same in NHS Ayrshire and Arran in relation to the 8:2 and 9:1 contracts? The British Medical Association makes it very clear that one of the big frustrations in trying to attract consultants to come to Scotland rather than other parts of the United Kingdom has been the 8:2 and 9:1 contracts. There has also been a range of other issues, but those contracts are a key factor.

John Burns: We have moved away from offering 9:1 contracts. The issue is about good job planning, whether we use 8:2 contracts, 9:1 contracts or whatever. We need to ensure that there is the right job plan for the service, and for the consultant as part of that team, which reflects all the work that a consultant does and not just the direct clinical care that they offer.

Anas Sarwar: I found it interesting in your answer to Willie Coffey's question on the things that are not in your control that the issue that you picked was workforce planning. The way in which workforce planning works is being redesigned, and we are waiting for the comprehensive workforce plan that will be published at the start of next year. We are trying to make it a national strategy, so how much connection is there between the health boards in creating that comprehensive workforce strategy? How is the absence of a comprehensive workforce strategy impacting on service delivery in your health boards?

John Burns: We have our own workforce strategy, and I am sure that all my colleagues in other boards have one, too. We are looking at workforce planning across the west of Scotland—I can speak only about the west—as part of the regional working that is under way. We think that it is important to be able to identify and support new roles beyond a single board, so important regional work in going on. That work will connect to the national picture, because it will connect to training programmes and training need. When I say that workforce planning is outwith our control, I mean that we do not control what we do with the training numbers. However, we can control our workforce plan and how we redesign our workforce so that it is based much more on multidisciplinary teams. That is the way forward.

Anas Sarwar: The workforce challenges connect to the service reform that needs to take place to make the system financially sustainable and sustainable for patients. Would it help local health boards if there was a national strategy and intention from the Government and from all political parties? We could be honest with the public and say that we will not magically find 5,000 people to fill the vacancies for nurses, GPs and consultants, or the money that is needed to do so, and that, if we want to make the service sustainable, we need a programme of reform across Scotland, which will involve all health boards. If there was that national intention and message from the Government and from all political parties, would that help with the local engagement that is needed and with your ability to persuade local people about the service changes that are taking place in individual health boards?

John Burns: There is no doubt that a common positive message across Scotland on reform and

the need for change to deliver safe, sustainable and high-quality care for the future would be an important part of moving forward quite difficult agendas.

Anas Sarwar: Is that common message missing just now?

John Burns: I think that we could do more.

Anas Sarwar: So you would like some leadership on that from the Parliament.

John Burns: Yes, it would be very positive if we had a common view on the need for reform and the importance of that reform.

Anas Sarwar: Excellent.

When we speak to national health service staff, it is clear that they are under more pressure than they have ever been and that they feel that there is not enough of them, which adds to the workload and pressure. Because of that, they fear what might happen to their delivery of care for patients. That situation also increases the risk of clinical errors or the perception of clinical error. On top of that, there is a growing feeling right across health boards that there is a culture of bullying and intimidation and a lack of a genuine whistleblowing process. I know that NHS Highland has had some particular issues with that. Can you address directly the point about a culture of intimidation and bullying and what seems to be the lack of a robust whistleblowing process?

John Burns: From the standpoint of NHS Ayrshire and Arran, we are very open and the whistleblowing process is shared across our organisation, so staff are aware of it. We have also worked very hard on culture and values in the organisation and have worked to engage staff on change. We do not get it right all the time and can always do better, but I think that we have a strong foundation in NHS Ayrshire and Arran.

Professor Mead: I agree that honesty and local engagement are critical going forward in NHS Highland. The staff are very tired and are often working in pressured circumstances. However, I am also optimistic, because staff are very keen to change. The support to be able to change and to have a conversation about why we need to change will be helpful for front-line staff.

The Convener: Professor Mead, you said in your answer to Mr Sarwar that there was a 50 per cent increase in the use of CT and MRI. Why is that?

Professor Mead: The technology has improved to allow imaging to show more diagnostic benefit, so we find that clinicians are continually now asking for the newest technologies and tests. The CT and MRI imaging machines are now becoming invaluable in diagnosis.

The Convener: So your diagnosis rates have gone up.

Professor Mead: Absolutely. The use of tools and techniques to make better diagnoses is increasing. Again, that is to be welcomed, but the lack of the radiologists who are needed to read those images puts huge pressure on the departments.

The Convener: Has the diagnosis rate gone up 50 per cent to match the expenditure on CT and MRI?

Professor Mead: I am not able to tie those two things directly together, because it might just be that people are using a different tool or imaging technique to be able to make a similar diagnosis. I do not think that there is a correlation between an increase in the use of CT and MRI and an increase in the number of diagnoses. They will just be using those techniques to diagnose in a different way.

The Convener: Those are clinical decisions, but CT and MRI are hugely expensive. How much is an MRI scan?

Professor Mead: I am afraid that I cannot tell you exactly, but we can find the information for you as a cost per case.

The Convener: My understanding is that it is quite a lot of money—it runs into thousands.

Professor Mead: Indeed, and the cost and time that it takes to report many hundreds of slices of those images is significant.

The Convener: Are there health economists in the Scottish Government who can marry those figures up? There must be.

Professor Mead: There must be, and I would welcome that.

The Convener: I have a question for you about the cost of locums in NHS Highland. You probably anticipated that we would ask this question. The committee looked at this issue when we took evidence from the Auditor General on her report on your health board. In your written submission, you very helpfully provided a breakdown of costs, so thank you very much for that. If I am reading your table correctly, the total pay costs for two locum doctors in your health board runs to over £900,000. Is that an effective use of taxpayers' money?

Professor Mead: It is stark, which is why we wanted to put that information into the public domain in the way that we have. I would say that it is a good use of taxpayers' money because we need to provide a sustainable service in the hospital concerned. It is a rural general hospital where we need to have a 24/7 emergency care response and the staff need to be expert in that

care and able to address anything that might come into a rural general hospital. Not having an appropriate senior-level response is not an option for us. It is geographically important to the Ambulance Service and the patients to whom we provide care.

The figure on the table of £900,000 for those two individuals is stark. That figure is there because we have managed to secure people who have wanted to come back on a regular basis and, therefore, have been paid and shown as two individual costs. They are two locums who have continually come back. Having the same people coming in on a regular weekend basis helps the team. Having 10 people coming in 10 times would have cost the same but would not have provided the continuity of care.

The Convener: I understand the reasoning around it and I agree with your decision that the hospitals must be staffed by people who can do the job. That is the right thing to do. However, as the accountable officer for NHS Highland, you must be tearing your hair out when you are approaching the end of the year and you find that you have had to pay nearly £1 million for two doctors. What is the process that leads you to the situation in which you need to pay out nearly £1 million of taxpayers' money for just two doctors? What would prevent that situation from arising?

Professor Mead: We do not address that only at the end of the year; we consider it throughout the year. The medical director is taxed with overseeing the costs of medical locums, and I take his professional advice on a weekly basis about what represents appropriate clinical care and cover for the various hospitals.

The Convener: What would prevent you from having to make that hugely expensive decision?

Professor Mead: Quite simply, recruiting high-calibre medical staff into those roles would prevent that. We are continually trying to do that in all the rural general hospitals.

The Convener: And what is the obstacle to that? Are we not training enough doctors?

Professor Mead: The role of the specialist generalist, if I might describe it as that—the individual in a small rural hospital who has to address anything that comes through the door—is not a role that is commonly trained now, and is not particularly attractive.

The Convener: Is that the fault of our workforce planning strategy?

Professor Mead: I think that it goes back even further to some of the training options. Certainly, NHS Highland is working hard to have junior doctors rotating through our rural general hospitals in order to make them attractive places for them to go in the future. We are talking about extremely challenging roles in those rural general hospitals, without large support teams that you might get bigger hospitals.

The Convener: Liam Kerr and Anas Sarwar have supplementary questions on this specific point.

Liam Kerr: On the point about the cost of the locums, those two individuals come through an agency, so there is an agency cost. Why are they not employees? Presumably, you offer to employ them. If that is the case, what salary do you offer them? Is it the same as what is on this table, or are you actually saying to locums such as these ones—I appreciate that we are focusing on these two, but the issue must apply across the system—that they will be paid less if they take an employed position with you than if they stay with the agency, even though it takes a 10 per cent cut or whatever?

Professor Mead: That is, indeed, the situation. We would always attempt to secure in-house locums or permanent staff first and foremost, or offer short-term locum posts. Where we have attempted all those things and have still been unable to address the issue, we have to go out to the market, because we have to secure the cover. We have a very tight process that involves going through one particular agency to secure individuals; it is not a completely open market.

Often, as the need for cover gets more pressing, either in a hospital such as the ones that we are talking about or in an out-of-hours service, market forces require us to pay more than we would pay as a salary. There are some individuals who will work as locums rather than choose to take a permanent position.

09:45

Anas Sarwar: This must be infuriating for you. I completely understand your frustration, because having to pay £900,000 for two doctors, which is almost the equivalent cost of nine consultants, must be hugely frustrating given the other financial challenges that you have. As you said, the cost is dictated by the market. The market dictates what you have to pay those staff, because you have to have those doctors in those settings in order to deliver the care to your patients that you want to deliver. How should the Government intervene to regulate this area? Should the amount that agencies charge be regulated? I am not saying that there should be a cap on what you can spend on locums and agencies—because you need to get in agency staff—but should we be looking at capping what an agency or an individual nurse or doctor can charge for a single shift, so that there is not this complete manipulation and abuse of

health service budgets as a result of the challenges that we are facing across the country?

Professor Mead: We chief executives have had the conversation many times about how we can manage the situation most effectively. Often, we—even together as boards—have held the line with agencies, but there comes a point, particularly in rural areas where there is a particular need, when we have to say that we need a doctor today. Therefore, it is very difficult to hold a party line, unless we get to the point where we say that we will not be able to admit patients to one of our hospitals.

Anas Sarwar: Rather than being left to the chief executives of the health boards, should that party line not apply nationwide and be put into law by the Parliament?

Professor Mead: In that case, to balance out the market, there would be some times when, for sure, we would say that we cannot have a doctor.

Anas Sarwar: When local people in Skye see £900,000 being spent on two doctors and then think about how they cannot have a GP out-of-hours service because it costs £1,400 a patient, do you understand their anger at that situation?

Professor Mead: Indeed, and I understand that we have to look at all the issues as a whole health board. The people of Skye would not necessarily be looking at what is happening in other parts of Highland; equally, the people of Skye would also benefit from having those doctors in their local rural general hospital if they needed that emergency access.

Liam Kerr: You said to Anas Sarwar that there are not enough consultants. In your submission, you say that one of the challenges to do with that is

"Increasing specialisation in medicine"

such that

"consultants are no longer trained in a way that allows them to work in generalist settings, such as Rural General Hospitals".

That is highly concerning. Have you raised that matter with the Scottish Government and/or the medical training facilities?

Professor Mead: Yes, indeed.

Liam Kerr: What response have you had?

Professor Mead: We are recognising that situation now. Certainly, the royal colleges are in conversation with us and the Government about how we might want to reconfigure the training for the future. As I have mentioned, we are benefiting from having trainees moving through rural general hospitals, and that training of generalism is now moving in an almost completely different direction from the superspecialism that we have seen in the past. However, we are not benefiting from having physicians—such as respiratory physicians or cardiologists; there are many things that they can do—that have maintained the skills to take on a role in small rural general hospitals, where many specialties have to be covered.

Liam Kerr: It surprises me that we are in this situation. Is the situation being addressed so that there will be such generalists in the future?

Professor Mead: The colleges are discussing that. I cannot speak for the actions that they are taking, but we are hopeful that people are beginning to recognise the importance of the generalism role as a specialty in its own right. In NHS Highland, we have certainly made many representations to try to rebalance how doctors are trained.

Liam Kerr: That might be something to put to the Scottish Government officials shortly.

In your submission, you go on to refer to the difficulty of GP vacancies. You suggest that you have

"developed a number of initiatives and ... approaches to address"

that particular challenge. Can you tell us what those approaches are and whether they are working?

Professor Mead: Yes. It is more difficult for GPs or independent contractors to identify and give an exact number of vacancies, but we still see vacancies in about 12 per cent of practices.

The initiatives that we have had to take are looking for other members to join the team who are not doctors but could undertake some of the functions that doctors might previously have led on. For example, some of our north coast practices now have pharmacy practitioners working at an advanced level. They work as part of the team and take a huge amount of pressure off the doctors. We originally did that as a trial in the north, and we have found that it is possible for us to recruit pharmacists and give them extended roles, working as part of a team, which takes significant pressure off the doctors on a daily basis. We are looking to spread that initiative across NHS Highland.

Liam Kerr: If we start from a position of saying that those initiatives are working—

Professor Mead: They are.

Liam Kerr: —to address shortages, how is that knowledge being shared? For example, is Mr Burns on the phone saying, "How are you sorting this out?"

Professor Mead: We regularly share knowledge at the chief executives' meetings and present to each other some of the innovative things that we have been doing. Most of our innovation has come out of immediate need, and some of our needs are more challenging in remote areas than in others. We are always happy to share.

Liam Kerr: I represent the North East Scotland region and we often have fairly similar challenges. I would be pleased if NHS Grampian, for example, was on the phone to you to ask what you are doing that is working. Is that happening?

Professor Mead: We do have those conversations. I do not recall that we have had a conversation about extended-role pharmacists, but I would be very happy to have that.

The Convener: Mr Bowman, you have been very patient.

Bill Bowman (North East Scotland) (Con): Can we go back to the information on the consultants? If I understand it correctly, one of them worked 5,188 hours. If my maths is correct, that is an average of 14 hours every day for 365 days.

Professor Mead: They will have been paid for out-of-hours work as well as in-hours work. They will also have been paid for overnight calls. One of the difficulties that we have with locum doctors is that they are paid even if they are not called out. They are available to us and often on site so that we can call them.

Bill Bowman: That just seems to be a very high number.

We are looking at a snapshot of this year. Will that individual have been working for you in the previous year? Are they continuing to work?

Professor Mead: Forgive me, but I cannot tell you about the previous year. We might have had other doctors. I can certainly tell you that there have been vacancies in that particular hospital for a number of years, so undoubtedly there would have been similar costs associated with maintaining 24-hour cover.

Bill Bowman: You do not know whether that individual has been there in the longer term.

Professor Mead: No.

Bill Bowman: Would you be happy if they had?

Professor Mead: I would always ask that we are looking to fill the post substantively. That would be the way to reduce the costs. If we had people in substantive positions in those hospitals, those costs would immediately reduce.

Bill Bowman: I do not want to get into specifics, but it is almost as if that person has been working there for a long time and is presumably quite comfortable with their role.

Professor Mead: I understand the point that you are making, Mr Bowman. As I have said, the medical director is overseeing the cost of locums and the way in which doctors are being used. He will be working with the local practitioners to decide whether to continue in this way.

The Convener: Professor Mead, I understand that you are looking forward to your retirement. Is that correct?

Professor Mead: Thank you. I will be leaving NHS Highland at the end of this year. I am not retiring; I am simply moving on to other things.

The Convener: I see. I wish you all the best in those posts.

Professor Mead: Thank you so much.

The Convener: What progress is being made with the recruitment of a new chief executive?

Professor Mead: A recruitment process is under way to recruit a chief executive. I understand that we have not yet secured a permanent chief executive but progress is being made in securing an interim chief executive for NHS Highland.

The Convener: There will be an interim chief executive. Has much progress been made with a director of finance?

Professor Mead: We are not out to advert for a director of finance; it is under discussion.

The Convener: Do members have any further questions for our witnesses?

Willie Coffey: I have a brief question. Professor Mead, at the beginning of the session, you said something about how it can take two and a half hours to get to a meeting within the board area. Do you not use information technology and things like Skype to have chats and meetings? Why do you need to drive for two and a half hours?

Professor Mead: We absolutely do that. We are one of the biggest users of Skype and videoconferencing. The NHS near me service will reduce the need for our patients to travel for out-patient appointments.

We were talking earlier about the importance of engagement. You will know that face-to-face engagement is important, so when we have those public meetings, we go in person.

The Convener: As there are no further questions from members, I thank you both for your evidence this morning. I will suspend the meeting

for a couple of minutes to allow the witnesses to take their places.

09:56

Meeting suspended.

09:59

On resuming—

Section 23 Report

"NHS in Scotland 2018"

The Convener: Item 3 is on the section 23 report "NHS in Scotland 2018". I welcome our witnesses from the Scottish Government: Paul Gray, director general of health and social care and chief executive of NHS Scotland; Christine McLaughlin, director of health finance, corporate governance and value; Shirley Rogers, director of health workforce; and Dr Catherine Calderwood, chief medical officer. I understand that none of you wants to make an opening statement, so I will move directly to questions.

I do not know whether Mr Gray watched the evidence that we just took on the two section 22 reports, when we heard good examples of the problems that the Auditor General has touched on in her 2018 overview of the health service. We discussed the costs of locums in NHS Highland. The committee is extremely worried that two locum doctors in NHS Highland have cost the taxpayer more than £900,000. How do you respond to that?

Paul Gray (Scottish Government and NHS Scotland): First, I acknowledge the concern. A substantial sum of money has been paid from public funds. I will ask Shirley Rogers and Catherine Calderwood to say a little about what we are doing to address such issues through our workforce planning and our approaches to medical staffing. I agree that those costs are very substantial.

The Convener: That is a big and shocking example of poor workforce planning in the NHS. We all know that we have issues with workforce planning, which you have admitted before, but how have we got to a situation where the open market is determining an exorbitant cost—more than £900,000—for two doctors to staff our hospitals, when the Scottish Government pays for the training of doctors right the way through?

Paul Gray: There are issues of rurality and there are international shortages in certain specialties—we are not alone in experiencing that. I ask my colleagues to give more details on what we are doing.

Shirley Rogers (Scottish Government): The convener is right to identify that there are issues of medical workforce supply and, as the DG said, those issues are not unique to Scotland. The Scottish Government has significantly increased the number of places at medical schools and in autumn 2018, for the first time in Scotland, we

introduced a postgraduate-entry medical degree, which is targeted at people who are a little more mature and who might be interested in working in rural and general practice. We are looking at transformed models of patient care in which general practitioners are not the only people who can provide healthcare services. The approach is a combination of increasing the supply, being as attractive as we can be as an employer—within the constraints of all the international challenges that we have talked about—and looking at a transformed model of how we deliver services. I do not know—

The Convener: If you will allow me to interrupt, the issue is not just supply. Certain parts of the country—rural areas are an example, but areas of deprivation are another—struggle to get general practitioners and consultants in a range of specialties. The issue is not just supply but getting doctors to the areas in which we need them. How are you tackling that?

Shirley Rogers: We are tackling that by working closely with the boards, by trying to make those roles as attractive as they can be and by trying to take a more diverse approach to workforce engagement and employment. We know that—

The Convener: That is not working. I visited the child and adolescent mental health service in Dundee this summer. It is supposed to have seven consultants in child and adolescent mental health but, at that time, it had only four consultants and could not get doctors to come to Dundee to work. As a result, only 41 per cent of children in Tayside see a mental health specialist when they need to. It is clear that the Government policy to get those doctors in place is not working.

Shirley Rogers: As you will be aware, this year, we published for the first time a workforce plan that starts to identify where there are particular challenges. NHS Education for Scotland and my team have worked through those shortage areas and what we can do to target them. For example, we have used bursaries to help with the situation; we have looked again at rural incentives in particular; and we have a new general medical services contract—

The Convener: When you say “bursaries”, do you mean bursaries to encourage people to train as doctors?

Shirley Rogers: They are for encouraging people to train and to come and work in our health service—full stop.

The Convener: Are you saying that we are not training enough doctors?

Shirley Rogers: We are training more doctors than we have ever trained before.

The Convener: Let me put this to you: we train many doctors in this country—you will know the figures better than me. However, I hear reports—I cannot get them substantiated by the General Medical Council or the BMA—that we lose up to 40 per cent of the trainee doctors whom the Scottish Government has paid to train through our universities and hospitals, because they go abroad to Australia or New Zealand.

The taxpayer pays for that training, but in NHS Highland, for example, we have to pay an additional almost £1 million to get two doctors to cover the hospitals. Why is the Scottish Government paying all this money to train doctors and then letting them go to other countries? Should there be some clause that ensures that they have to stay and work in the NHS?

Shirley Rogers: There is an argument to be made there but, to be fair with regard to the numbers, we know that young people like to explore careers in different parts of the world—and that is what they do. To be fair, the vast majority of people who leave Scotland after medical school go to practise in England and then come back. They might go, but that does not mean that some do not return—in fact, many do.

The fact is that there is an international marketplace for medicine. We are talking about highly intelligent and highly trained people with skills that are marketable across the world, and we try to do all that we can to make staying and practising medicine in Scotland attractive. A large proportion of our medical students stay and practise here.

The Convener: I go back to the two locums whom I mentioned. Have you considered capping the amount of money that they can be paid?

Shirley Rogers: Catherine Calderwood might be in a better position to talk about the impact on services, but we have considered whether there are other ways of helping boards to manage such situations, which might involve establishing and reinforcing Scottish arrangements around bank and agency staff and so on.

Dr Catherine Calderwood (Scottish Government): As far as doctors in training are concerned, we would give locum positions for an unlimited time with a view to filling those posts with people on permanent contracts. I believe that one of the doctors you have referred to is a surgeon and, given the essential emergency and elective services that they provide, one assumes that, if the post was empty, patients would need to travel for elective surgery, and the rota might be unsustainable for other doctors to cover. If a rota has only three or four people on it, one gap leaves the whole service very fragile.

The Convener: Nobody is disputing that the doctors should be there to cover patient need—the issue is the amount that the taxpayer is having to pay. Should there be a cap on that? The Scottish Government is letting market forces determine how much those doctors are paid, because they are not on an NHS contract.

Dr Calderwood: I go back to Ms Rogers's comments and point out that this is a marketplace. If we said, "We are not going to pay you X to do this job," the people would go elsewhere. They would leave the service if they could get more money or a longer contract somewhere else.

The Convener: I say with respect that I do not think that the public see our NHS as a marketplace. They feel that they pay their taxes, and their doctors should be on NHS contracts. Why will the Scottish Government not enforce that?

Dr Calderwood: I come back to your point about medical students leaving. We now understand that issue a lot better, so we train a lot more medical students per head of population than the rest of the UK in our five medical schools. We have always been a net exporter of doctors; indeed, you will find Scottish medical students and doctors who trained in Scotland all over the world—

The Convener: Is that a good thing when we cannot staff our own hospitals?

Dr Calderwood: I am about to talk about what we are doing to attract people. We know that the biggest factors in keeping doctors in Scotland are whether they trained at a Scottish medical school and where they went to high school, so we are doing a lot of work on encouraging medical students from all over Scotland, but particularly those from remote and rural areas, to stay here. They might leave in the early part of their career, but they will come back and establish roots around where they grew up.

The Convener: If we pay to train doctors, should they be made to sign up to spend a certain amount of time working for the NHS in Scotland?

Dr Calderwood: That has been considered. One of the difficulties for Scotland is that, if that was not a condition in the rest of the UK, our Scottish medical schools might be less popular. That would have the knock-on effect of fewer people training and, therefore, staying here. Unfortunately, the UK marketplace for medical student places means that, if we were to do something different, we would be disadvantaged.

Angela Constance (Almond Valley) (SNP): I will pick up from where Dr Calderwood left off. I am interested in practical examples of things that we are doing to get out of the locum loop, and to address some of the broader workforce issues. I am aware of the refugee doctors and dentists programme, whereby doctors and dentists can, for a modest investment, be helped to convert their home-country qualifications so that they can work in our NHS. I appreciate that immigration and asylum are not within the gift of the Scottish Parliament, but I am sure that we could be doing more in that area.

You touched on the widening access agenda; I would like you to say more about that. There are high schools up and down the country that have never had any kid go to medical school, so I would like to hear about the work that you are doing to get more working-class kids and young people from rural areas into medical schools.

The Convener: Will you ask a question, please, Ms Constance?

Angela Constance: I would also be grateful if you could say more about upskilling folk for roles such as advanced nurse practitioner. What are the barriers to the practical measures that you are taking? What opportunities exist?

Dr Calderwood: I will deal with widening participation first. We have a target for the number of places for medical students. We must widen access to other university courses, too, but we are specifically considering medical students at the moment. Each medical school must have 10 people per year coming from schools of the kind that Angela Constance mentioned, which might never have had a pupil go to university or medical school.

We also have the gateway to medicine course that started last year. Of the 25 young people who took the University of Glasgow's gateway to medicine course, 21 are going on to medical school and four are doing paramedical science degrees, which represents a very high success rate among people who would not otherwise have got through the medical student exams. They do a year to prepare them to get into medicine. That has worked extremely well.

On widening participation more generally, the Medical Schools Council has a scheme in which people like me and colleagues from the NHS go into schools of the kind that Angela Constance mentioned to talk about careers in medicine and in the health service in general. I have been to several schools, and I will go to more in January.

The University of Edinburgh's medical school has a new programme that will each year take in 30 medical students who have healthcare professional backgrounds. That programme will start in 2021, and will be expanded if it is successful. It will allow people to study part time, so that they will be able to continue to work as nurses, physiotherapists or whatever their current

NHS job is. It will be an online course until the later years, when the students will need to be present for learning with patients. We hope that that will attract people who know what it is like to work in the NHS and who will stay there. It is likely that those students will be more mature students, who evidence suggests will not leave the country. Those are tangible practical measures.

The other part of Angela Constance's question was about reliance on medical rotas. The traditional model has the medical consultant at the top, with registrars or doctors in training below them, and then another level of more junior doctors below them. We realised that, for many of those posts, other practitioners—advanced nurse practitioners, in particular—can do an extremely good job. There is supervision through the consultant being on call. We have changed our attitude in relation to the role being performed by a doctor.

The committee knows extremely well the difficulties in paediatrics, and psychiatry has also been touched on. There are real shortages in those specialties. We are looking at how to provide services differently. For example, at Dr Gray's hospital in NHS Grampian, advanced nurse practitioners are on a shortened course—one year, rather than two—so that they can come into the service earlier.

10:15

Colin Beattie: I would like to explore a few issues around governance and leadership. There are a number of references in the report to the quality of board members and the lack of a consistent approach to achieving the appropriate levels of knowledge, skills and expertise. I believe that the Scottish Government is developing a range of initiatives in that regard. In the light of the Auditor General's report, do you think that the initiatives are adequate to address those issues?

Paul Gray: We commissioned John Brown and Susan Walsh to review the governance issues in NHS Highland. They produced a report, which in turn produced a blueprint that is being applied to all NHS boards in Scotland, and is to be fully applied by the end of this financial year. In other words, all boards should be conforming with the blueprint by the beginning of the next financial year. I think that that will address some of the issues that the Auditor General raised.

We have strengthened our support for induction of board chair and members, and the cabinet secretary has made it clear to the chairs of the boards that she expects the findings and good practice from the exercise that was carried out in NHS Highland to be applied in all their boards. We will not simply take that for granted, but will follow up and assure ourselves about that.

Colin Beattie: I do not think that the blueprint that you referred to has been shared with the committee.

Paul Gray: I cannot say whether it has, but I can see no difficulty in our doing so.

Colin Beattie: Convener, it might be useful if we see a copy of that blueprint, in view of our concerns over governance in general.

You have used NHS Highland as an example. As a committee, we see only the things that go wrong, and not the things that go right. How do you transfer best practice from one board to another? Addressing problems is one thing, but adopting good practice from boards that are getting it right is equally valuable.

Paul Gray: That is part of the purpose of the blueprint. We took the view that it was not sufficient simply for NHS Highland to learn the lessons of the review by John Brown and Susan Walsh review; we thought that those lessons should be applied across Scotland.

Again, the cabinet secretary has raised directly with the chairs of the health boards the importance not only of understanding and sharing best practice, but of implementing, spreading and scaling it. I have discussed with the board chairs how they can do that through the work that they are doing on innovation. There are pockets of good practice, but we need to get better at ensuring that they are embedded everywhere.

That said, when issues arise, we try to learn from them. We also make sure that we use the board chair meetings to discuss things that boards are finding work well. For example, when NHS Lanarkshire went through a period of significant difficulty at the end of 2013, we put in a support team, and the findings of the support team were shared with all boards. Some governance support that we now give to boards that experience difficulties is drawn from the good practice that we have learned from previous incidents.

Colin Beattie: You say that you shared with the boards the lessons that were learned from NHS Lanarkshire's difficulty in 2013. Clearly, some boards did not learn those lessons, because problems have come up subsequently.

Paul Gray: Among the things that we are committed to doing, and on which the cabinet secretary is leading, are improved sharing of best practice and ensuring, and assuring ourselves, that it is being embedded everywhere.

Colin Beattie: The blueprint is obviously something that the boards can use as a learning device, but the quality of NHS board members is

variable, as the report mentions. Again, we see weaknesses only when things go wrong. Frequently—and not just in the NHS—weaknesses in boards have exacerbated problems. How will you deal with that? The blueprint will not, by itself, address that.

Paul Gray: No, it will not. On recruitment of board chairs, we have moved in the past year to a process of values-based recruitment, which is much more thorough and detailed. It involves not only a paper submission and an interview, but a battery of psychometric tests that are conducted by qualified people, and a role-playing exercise that is overseen by qualified people. From feedback on those elements, we get a much better picture of the skills and capacities of individuals who come forward. The Commissioner for Ethical Standards in Public Life in Scotland, who oversees the public appointments process, has been very supportive of the approach that we are now taking.

At this stage, that process is for board chairs—I want to make that clear to the committee—but I believe that elements of the process could be applied to board member recruitment. I am also clear that the quality of appraisal of board members needs to continue to improve, in the light of what we are seeing.

That said, I do not want to leave the committee with the impression that we do not have some very good board chairs and board members: we do, and I engage with them directly. The cabinet secretary engages directly with board chairs, as the committee knows.

Colin Beattie: In paragraph 69 of the report, the Auditor General talks about the need for more effective challenge by board members. That has consistently been a weakness that we have seen in boards in which things have gone wrong—at least, in the NHS. How will you address that for existing board members?

Paul Gray: One of the things that I have been clear about when recommending chairs to the cabinet secretary for appointment is that I take them through questioning on how they will move from a process of seeking reassurance—which is, in my view, insufficient—to a process of assurance that involves them testing the material that is put before them, while ensuring that boards are not swamped by paper but get the information that they need and have the time and skills to interrogate it.

When we recruit board members, we pay very close attention not only to their skills and capabilities, but to their fit and the mix in the boards. In other words, we make sure that we have people who are financially qualified and able to scrutinise the clinical governance arrangements that are in place. The approach is therefore not just to have a baseline to ensure that every board member is the same but, rather, to make sure that members fit and that the mix of the board is adequate for its needs.

Anas Sarwar: I want to return to workforce issues for a moment. I will follow up the convener's questions to Shirley Rogers and Dr Calderwood. Shirley Rogers said that we have a published workforce plan for the first time. Why has it taken 10 years and the current workforce challenges for us to finally publish a workforce plan? Also, why do we have, rather than a comprehensive integrated plan, three separate plans based on the old model and not on the modern model that we want to project of the national health service and the social care service?

Shirley Rogers: I have worked in the NHS in Scotland for 23 years: workforce planning has been present for all that time. What is different now is that there are the elements to which Anas Sarwar referred. We are doing workforce planning with NHS partners and with others, and we are doing it in a manner that reflects the holistic nature of the NHS, rather than just secondary care in hospitals, just primary care outside hospitals, just doctors, just nurses or whatever.

As you know, the plan was published in three phases. The first phase dealt with secondary care and the integrated landscape, with colleagues from the Convention of Scottish Local Authorities and so on. In the second phase and latterly it has, because of the negotiations around the GMS contract and various other bits and pieces, dealt with primary care.

As the committee is aware, we intend to publish an integrated workforce plan; work continues so that we can do that in the spring. The work reflects the changing dynamic, which has not been the case and was not the case 10 or 15 years ago, when we planned speciality by speciality for doctors and, separately, for nurses and allied health professionals.

Anas Sarwar: Was not the comprehensive plan meant to be published this year?

Shirley Rogers: We have published the three elements of the plan, as was committed to.

Anas Sarwar: There are three separate plans, though, which are based on the old model.

Shirley Rogers: They are three separate plans that are based on the new methodology, which is another important aspect, because in order to be able to plan with multiple employers, we needed a shared methodology.

Anas Sarwar: When will we have the new comprehensive plan based on the new model? When will we have a manageable vacancy rate in

the national health service and social care service?

Shirley Rogers: The vacancy rate in the NHS and social care will always be challenging for us. We will continue always to have to ensure that we have sufficient staff. As you know, health and social care employs approximately 14 per cent of the working population of Scotland. With numbers on that scale, there will always be a challenge in making sure that we have sufficient staff, which is influenced by other factors including European Union withdrawal and other bits and pieces that we need to consider.

As the CMO pointed out in previous evidence, we are targeting the areas in which we know that we face specific challenges. Perhaps I can give the example of a challenge that is not medical. We know that we have a challenge with healthcare support—in particular, in respect of people who work in the care-home sector. For the past two or three years, we have been developing an education model that allows us to have people learning while they work.

Anas Sarwar: I will give you some medical examples. We have 3,500 nurse and midwife vacancies in the national health service, one in three GP practices reports a GP vacancy and one in three radiologist posts is vacant, as we heard from NHS Ayrshire and Arran and NHS Highland. Based on your comprehensive workforce plan, when will we sort out the radiologist and GP crises, and when will we get down to 1,000 nurse vacancies from 3,500?

Shirley Rogers: In radiology, some of the solution will be about recruitment—as you know, we have some targeted activity in that space—but some of it will be about finding different solutions to the challenges. For example, in the east of Scotland, radiology services are being developed using digital and technical platforms that allow X-ray films to be read, appropriately, by clinicians from every part of the region.

It is not simply about a number: I think that the Audit Scotland report says that this is not just about money and supply. It is about transformation and how we use technology better to support services that need to be provided and which are under pressure. An X-ray film can be read by competent people in a number of different locations. That allows us to make use of the technology that we need to use and it allows us to make good the supply issue.

However, can I say, specifically, that in five, 10 or 15 years we will never have a GP vacancy? No, I cannot—and you know that.

Anas Sarwar: No—I am not saying "never". At the moment, the situation is not sustainable. Health boards tell us that it is not manageable. The vacancies are not managed, at the moment. At what point will we have a transformation plan for services, and a workforce plan that will fill the vacancies and give our health boards a manageable situation? You can surely give us a timeframe for that. Will it be a year, two years, five years or 10 years?

Shirley Rogers: It will be a case of incremental development. We now have a medium-term financial framework that allows boards to plan. We have a number of issues in relation to access that would allow us to increase our supply. We look at training ratios: for example, in areas in which we have shortages, we now train more than one for one. In paediatrics, we train 1.6 for one, which reflects the changing patterns of work that people want to enjoy. People do not necessarily all want to—

Anas Sarwar: You must have an ambition date—a hope that you will have it done in two, five or 10 years.

10:30

The Convener: To be fair, Mr Sarwar, I point out that we have asked Ms Rogers that question a few times now and she has given an answer.

Liam Kerr: The workforce issues are hugely concerning, but all those people need to work somewhere. The report also discusses the capital investment that is required in the estate and talks about a backlog of £900 million-worth of maintenance, 45 per cent of which is urgent, significant or high risk. What is the Scottish Government's response to that? Given the financial challenges that we have been looking at, how on earth is the NHS supposed to cover that?

Christine McLaughlin (Scottish Government): You are right that the level of backlog maintenance has stayed relatively static for the past few years. That is one of the factors that we look at in capital planning but, as well as ensuring that the buildings are safe and usable, one of the most significant answers on backlog maintenance is to look at our programme for the replacement of facilities as part of service redesign. The answer on backlog maintenance is not to spend the sum of £900 million to bring those facilities up to the level that we would want; in some cases, the answer will be additional facilities. Our longer-term capital investment strategy is to look at the priorities across the country. We have a national infrastructure board that ensures that we prioritise across the whole of Scotland and do not focus on only parts of the country.

We have said in response to the report that we are now developing a capital investment strategy

that will look to the longer term. We need to be able to look 10 or 20 years in advance when we think about our infrastructure. As members know, a typical new hospital build will take around seven years from the first strategic case that the board makes through to its being in use. Therefore, it is important to look further ahead.

Our annual investment from capital is split between essential maintenance across the service and investment in new facilities. We have recently seen the opening of the new Dumfries and Galloway royal infirmary, which is a good example of our answer on backlog maintenance.

Liam Kerr: I hear that answer, but paragraph 33 of the report says:

"As the way healthcare is delivered changes, the existing NHS estate will need to adapt to reflect this. The Scottish Government has not planned what investment will be needed."

You talked about a capital investment strategy, but the report seems to suggest that there is no such strategy and that the planning is not being done. Has the Scottish Government really not planned what investment will be needed? In any event, how can the NHS continue to deliver services in the future without the buildings and infrastructure to do so?

Christine McLaughlin: I agree that that will be one of the most significant areas for us to focus on over the next few years.

Liam Kerr: Has it not been focused on already?

Christine McLaughlin: We should look at the number of new facilities that have been opened over the past few years, going back to the Queen Elizabeth university hospital. There was an £842 million investment in that facility. It is not the case that we are not investing, but we always need to look ahead in making use of the funds and prioritising correctly. The work that we are now doing builds on things such as the regional plans to ensure that we are looking at the right facilities across the whole country. As Shirley Rogers said about the workforce, it is not that things do not exist, but it is really important to look at the short term, the medium term and the long term. The strategy is about the very long-term approach.

Liam Kerr: Let me be clear. The report says:

"The Scottish Government has not planned what investment will be needed."

Is that a fair statement? Is that the case?

Christine McLaughlin: No—we have not not planned. We are doing work to ensure that the regional plans for the next 20 years are in place, but the strategy that we are now developing is new. I do not have a strategy just now that I can say is the one that we have—we are developing something for the future.

Liam Kerr: When will it be developed?

Christine McLaughlin: We are doing the work just now, and we have said that we will publish something by the end of this financial year that sets out our approach.

Liam Kerr: So there will be something that we can have a look at by April, I presume.

Christine McLaughlin: That is what we are working to.

Liam Kerr: Splendid. Thank you.

Willie Coffey: Have you done any modelling of the impact of Brexit on the workforce?

Paul Gray: Yes, we have.

Willie Coffey: What is the message that you are picking up from that?

Paul Gray: Shirley Rogers is leading on that, and she and the CMO can tell you more about it. We have done quite significant work on that.

Shirley Rogers: I am sure that everyone around the table will understand that the model that is emerging for Brexit is changing fairly frequently and at pace. A number of concerns emerged around particular elements, such as the mutual recognition of qualifications, and we needed to consider whether arrangements would be in place to enable us to continue to deploy people who trained in the EU27 nations. We now have a position in respect of that.

We are currently operating the advance pilot of the settled status scheme to enable members of our NHS and health and social care staff who are from the EU27 countries to apply for settled status, and we understand that people are starting to do that. We accept that there are some messaging issues and other concerns have been raised with us around circumstances that we may or may not find ourselves in, depending on the nature of the deal under which we withdraw from the EU, but we hope that those issues are largely in a manageable form.

The bigger issue for us at the moment is the concern around the supply of people choosing to study, live and work in the United Kingdom after Brexit. The chief medical officer has already identified that the strongest factor in someone's choice about where to practise medicine is where they went to medical school—we know that there is a huge and positive correlation between where someone went to medical school and where they practise later. However, we are starting to see some of those expressions of interest in places dip a wee bit. Committee members will be aware that the number of applications from the EU27 nations

to join the Nursing and Midwifery Council has significantly declined—the number has gone from approximately 8,000 to fewer than 100 in the past year. Those supply issues are encouraging us to work hard to grow our own, as it were.

Some of the issues that Catherine Calderwood talked about in relation to medicine have been replicated, with extra effort, around schools of nursing and, in particular, around healthcare support workers, as we know that the proportion of EU nationals is higher in that area than in others. We are working closely with colleagues in local government and in other sectors to try to ensure that we have a supply pipeline in that respect. We are making a concerted effort to address the supply pipeline and to ensure that we can retain the EU citizens who work in our system, by assuring them that they are very much wanted in that space and ensuring that the messaging around that is positive.

Willie Coffey: What do you think will be the likely impact on NHS staffing and recruitment of the £30,000 salary limit that was announced yesterday in the new immigration policy?

Shirley Rogers: We know that the cut-off point of £30,000 will impact on some of our nursing grades and on some of our junior doctors. However, the biggest proportionate hit will be on the healthcare support worker area. That is a challenge to us. Low pay does not necessarily indicate low skill, of course. Healthcare support workers might not be paid very much, but the skills and abilities that they bring are critical to how we run our social care programmes.

Willie Coffey: When I sat on the committee a number of years ago, Robert Black, who was Caroline Gardner's predecessor, warned us about the days facing the NHS and how difficult it would be to sustain and deliver the service as it was. More boards are reporting overspends, the numbers are increasing and the sizes of the overspends are increasing, despite record funding for the NHS. Another £730 million is going in next year. Where are we with the transformation strategy that we are pinning our hopes on? How consistent is that across Scotland? When will we begin to see some of those overspend numbers coming down because of the benefits of the transformation strategy?

Paul Gray: I will bring in other colleagues, but I first want to draw out three things.

First, the ministerial steering group has commissioned a review of health and social care integration. Sally Loudon and I co-chair the group that will report to the ministerial steering group on that in January 2019. A key impetus behind that is to accelerate the pace of change through health and social care integration and—to pick up on the points that Mr Beattie and others have made—to share and implement best practice.

Secondly, it would be useful if the chief medical officer for Scotland said a little about the work that she is taking forward through the realistic medicine programme, because that involves genuine and sustainable change that will make a difference to the way in which we engage with patients and the way in which diagnosis and treatment are done. Shirley Rogers may be able to say a little more about the fact that we are seeing a reduction in the rate of prescribing through the work that we are doing with pharmacists and patients to ensure that there is appropriate prescribing and to avoid polypharmacy—that is to say, giving people too many medicines. We can cover those points if the committee would like us to.

The Convener: Dr Calderwood, what is your take on transformation? Is it going far enough and fast enough?

Dr Calderwood: The realistic medicine that we are promoting has started in Scotland and is now all over the world. We talk to people about what they actually want from their medicine. The fact that we can prescribe something does not mean that it will be the right thing for somebody. One person may want to run a marathon and someone else may just want to be able to walk their dog in their garden. Shared decision making allows us to take a personalised approach to people's care, which we have probably not refined as well as we should have done. Within that, we need to talk about value-based healthcare, which means value for the person and also value for the public purse.

We believe that we are the first country in the world to do this. We have a training programme that matches clinicians and people from the finance department of their health board to learn together about value improvement training. It sounds naive when I say out loud that doctors are not given an understanding of the finances in their training, but we know that people in finance are working on a different column of numbers, so we have brought them together in an initiative that will spread. We will have trained 200 people in this first year, and we have funding to continue that training. As you can imagine, the small number of people in the boards who are trained will then train others.

We are also working on exposing where there is variation in practice, which can lead to variation in outcomes. At the moment, our rate of primary hip replacements varies by a factor of fourfold across Scotland and primary knee replacements vary by a factor of sevenfold across Scotland, but the patients do not vary by those factors, so it may be that some people are having procedures that they do not need or people in other areas are not having what they should have.

We have published three maps showing variations in Scotland, and we plan to publish another 10 by the end of the financial year. I am not going to tell orthopaedic surgeons how many knee replacements they should be doing but, by asking the questions, we are exposing why practice across what is a small country should be so different. We are looking at rates of childhood obesity, and the clinical communities, doctors and healthcare professionals are really welcoming that, because they want to have those conversations. They often talk to me about feeling that they do not have permission to talk to people in that way.

10:45

I will be brief, but I must mention the first-ever citizens jury in Scotland, which has just finished. We invited people over the age of 16 to come together over three weekends to talk about some of the difficult questions that we are considering. We were a victim of our own success in that. We calculated the number of people to invite based on the numbers who vote and how many people turn up for ordinary juries, but we were oversubscribed by 50 per cent and we had to turn away people who wanted to take part. I have seen a draft of the recommendations that the people of Scotland have come up with, and they are really supportive on those difficult questions about value, values and improving how we deliver healthcare. The process will not be quick, but we have started the conversation.

Bill Bowman: I want to go back to the cost of locums. One of the issues when we discuss that is that, although we speak about agencies, I am not sure that I or others know very much about those agencies. Who are they? Are they regulated? Do you approve them? How do you manage your buying power so that the boards here and those in the rest of the UK do not have a bidding war and push up the costs for the same people, which would be to nobody's benefit?

Paul Gray: I will bring in Shirley Rogers on that in a second, but it is probably worth saying that medical agency spend in NHS boards fell by 5 per cent between 2016-17 and 2017-18, and locum spend fell by 10 per cent between those years. I make that point because, although there are high costs that the committee has rightly drawn attention to, we are working hard to bear down on those and not let them run away from us.

The use of locums is important. I do not want to reopen the point about Highland, but the two locums in question were at the Belford hospital and the Caithness hospital in Wick. Those are not large hospitals that can flex their workforce particularly easily. The situation might be different for a big hospital. As the CMO said, the local community would have had to travel substantial distances had those services not been available, particularly given the types of skills involved. There was also a possible impact on emergency surgery.

Shirley Rogers might say something about the way in which medical agency staffing is operated.

The Convener: Please be as brief as you can, Ms Rogers.

Shirley Rogers: There is no reason for us to be concerned about the quality of the people who come to us from the agencies. They are run through commercial organisations and they contract with boards. There is a national contract that is used and that is regulated—

Bill Bowman: Is there one agency, or are there two or five?

Shirley Rogers: There are a number of agencies.

Bill Bowman: Roughly how many are there?

Shirley Rogers: In regular usage, there are probably four to six, so there are not thousands. There is a distinction between that and the bank, which is the NHS's own staff. Nothing suggests to me that there are concerns about the quality of what we get, although clearly we all have the ambition of having full establishments and using our bank where possible. The point that I would make, perhaps more bluntly than the director general did, is that we utilise the agencies in order to preserve safety for patients.

Bill Bowman: My point was really about how you manage the relationship so that you are in control. I suppose that you are a large purchaser, so I would think that you have some sway over the agencies and the setting of rates.

Shirley Rogers: There is a national prototype contract that is supplied from NHS National Services Scotland to boards for their use. The boards are not required to adhere to it absolutely, but they can draw on it if they wish.

The Convener: Forgive me, but I am still not completely sure that I follow the issue about locums. Why would a doctor take an NHS contract if they can make £400,000 going through an agency to work in NHS Highland?

Paul Gray: They might want security of tenure, they could have certain views about their values or they might have a desire to work in one place and have certainty in that respect, or want the ability to settle their family in a particular place because they have certainty about the length of their employment. There are many reasons why people—not just in medicine, but in many professions—might choose locum or agency employment or fixed, substantive employment with an employer.

The Convener: We know that many people do that, but the locum and agency option is open and working—indeed, it is thriving—in Scotland. Does the power not rest with the Scottish Government to close down that option and save the taxpayer a lot of money while providing the same service?

Paul Gray: That power does rest with us. We could close every contract and cease to employ locums tomorrow, but I would not like to estimate the number of people who might die as a result. I think that that would be a very dangerous thing to do.

I whole-heartedly accept your point about the expense of some of this and the importance of bearing down on it, and I have tried to give the committee some evidence of how we are seeking to do that. However, as Ms Rogers has said—and I am sure that the CMO will support me in this—there are significant patient safety issues at stake here. What if people were taken out of the Belford hospital? It is not a big hospital. What if people were taken out of Wick? The good folk of Wick would not want to have to travel—

The Convener: With respect, Mr Gray, I have already made it clear that I am not suggesting that the doctors be taken out. I am suggesting that NHS Scotland, as the main employer of doctors in Scotland, manages its workforce and ensures that hospitals have the doctors that they need. Clearly, these doctors exist, but the option is open to them to go through an agency instead of being on an NHS contract.

Paul Gray: That might be a lifestyle choice or a choice related to the point that they are at in their career—

The Convener: But you have left that choice open to them.

Paul Gray: Indeed we have, and I believe that we should continue to do so. I am happy to say that unequivocally to the committee.

The Convener: Turning to the Auditor General's report, I note that in paragraph 62, which looks at leadership, she sets out at least six bullet-pointed examples of what is happening at the top of boards, with struggles to recruit chief executives and directors of finance, the establishment of various interim positions and high turnover of non-executive board members. Do we have enough people to run our health boards?

Paul Gray: We have a chief executive in place in every health board—

The Convener: Some of them are interim positions. Is that not correct?

Paul Gray: The chief executive of NHS Grampian is an interim position. Because Professor Logan is leaving at the end of the year, we took what I think was the right decision to appoint a new chair and allow them to oversee the substantive recruitment of the chief executive. We have also recruited to the state hospital. Either Shirley Rogers or I can give you a list of places—

The Convener: The Auditor General has helpfully done that for us. My policy question is: how do we get people in place who will run our services for the long term? What paragraph 62 shows is quite a hotch-potch of interim positions, struggles to recruit people and so on.

Paul Gray: I am reading that paragraph, and what I am telling the committee is that we now have a substantive appointment in NHS Orkney, we have—and have had for some time now—a substantive appointment in NHS Greater Glasgow and Clyde, and we have a substantive appointment to the Golden Jubilee national hospital. At the time when the Auditor General wrote the report, what she said was entirely factually accurate. However, we have moved on since then.

The Convener: Do members have any more questions for our witnesses?

Anas Sarwar: I have some questions for Mr Gray. First, Mr Gray, I want to thank you for your work over the past two and a half years. We have had our fair share of friendly arguments and discussions, but you have been very open and I wish you all the very best for the future.

I want to take advantage of your appearance here and ask you a couple of questions. You might be less on the leash with regard to responding to some of these issues but, being the consummate civil servant, you might well bat them off.

The Convener: Perhaps I should say, Mr Sarwar, that I expect Mr Gray to come before the committee again before he escapes from the Scottish Government.

Anas Sarwar: I look forward to that appearance. I have a couple of questions related to what we have discussed today. The convener talked about the number of people in our health boards, and I note that, with regard to the vacancy rate, the national health service is short by more than 5,000 people—3,500 nurses, 900 GPs and so on. Should we just be honest with the public? Should we tell them that we are not going to find 5,000 people and that, as a result, we are going to have to change the model of care with a real programme of reform coming from and led by the Government? Would you advocate and support such a move?

Paul Gray: A significant investment in primary care has been announced and we should allow that £250 million over five years to take its course. There has also been an announcement about an

additional 800 mental health workers and we should allow that to take its course, too.

The fact is that there is an international shortage of radiologists. There is nothing that we can do to prevent an international shortage but, as Ms Rogers said, we do not absolutely need to have everything done by radiologists. They are highly skilled individuals, but there are opportunities for others to participate and technology can make a difference, too.

Overall staffing levels are up. I can give you the detailed numbers, but I point out that, in the most recent quarter, there has been a reduction in the vacancy rates for consultants, nursing and midwifery and AHPs. Those rates are coming down.

I do not mean to be flippant—this is a genuine point—but the 140,000 whole-time-equivalent staff who work in the NHS did not come from nowhere. They came from the workforce planning that we have done. As Ms Rogers said, we have substantially enhanced that.

Anas Sarwar: I accept that, but I actually asked a different question. I accept everything that you have said about the recruitment challenges and what you have done to counter them, but my point is a much broader one. Do we need to accept that we are not going to magic up 5,000 people, that there needs to be a radical transformation of how we deliver services in Scotland and that leadership needs to come from the Scottish Government with regard to putting in place radical reforms and a new model of care that takes this Parliament and, more important, the public and the people who work in our national health service with it? Does that need to happen?

Paul Gray: Nobody is disputing the need for radical change in any way whatever. However—and I am not making a point about particular terms of office or sessions of Parliament—the changes that have been made and the developments over the past few years have been substantial. For example, people are now being cared for at home who would not have been 10 years ago, and they are being treated in different ways. If you go to the Golden Jubilee national hospital, you will see the supported discussions that people have with a nurse at one end and a doctor at the other to ensure that they are cared for and treated appropriately and they do not have to come back from, say, Orkney after they have had surgery.

We are making significant advances. I expect the future to be very different from today, in the same way that today is very different from 10 years ago.

The Convener: As members have no further questions, I thank the panel very much indeed for their evidence, and I close the public part of the meeting.

10:58

Meeting continued in private until 11:13.

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