OFFICIAL REPORT
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Public Audit and Post-legislative Scrutiny Committee

Thursday 5 March 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 5 March 2020

CONTENTS

PUBLIC AUDIT AND POST-LEGISLATIVE SCRUTINY COMMITTEE
7th Meeting 2020, Session 5

CONVENER

Jenny Marra (North East Scotland) (Lab)
*Anas Sarwar (Glasgow) (Lab) (Acting Convener)

DEPUTY CONVENER

*Liam Kerr (North East Scotland) (Con)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor June Andrews
Dr Caesar (Scottish Government and Project Lift)
Angiolina Foster (NHS 24)
Theresa Fyffe (Royal College of Nursing Scotland)
Caroline Gardner (Auditor General for Scotland)
Professor Paul Gray (University of Glasgow)
Dr Donald Macaskill (Scottish Care)
Lewis Macdonald (North East Scotland) (Lab)
Dr Lewis Morrison (British Medical Association Scotland)
Carol Shepherd (Medacs Healthcare)

CLERK TO THE COMMITTEE

Lucy Scharbert

LOCATION

The Mary Fairfax Somerville Room (CR2)

Scottish Parliament

Public Audit and Post-legislative Scrutiny Committee

Thursday 5 March 2020

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

Acting Convener

The Deputy Convener (Liam Kerr): Good morning and welcome to the seventh meeting in 2020 of the Public Audit and Post-legislative Scrutiny Committee. I ask everyone to switch off electronic devices or switch them to silent mode so that they do not affect the committee's work.

Our convener, Jenny Marra, has started her maternity leave and we all wish her well. As deputy convener, I will convene the meeting until the committee chooses its acting convener under agenda item 1.

I welcome Lewis Macdonald, convener of the Health and Sport Committee, who joins our committee for this morning's round-table session.

Our first agenda item is the appointment of an acting convener. Yesterday, the Parliament agreed, under rule 12.1A of standing orders, that an acting convener of the Public Audit and Post-legislative Scrutiny Committee should be chosen for the period from 5 March 2020 to 9 September 2020. The background to and procedure for the process are explained in committee paper 1A.

The Parliament has agreed that only members of the Scottish Labour Party are eligible for nomination as acting convener. I understand that Anas Sarwar is the party's nominee for the post. Are we agreed to choose Anas Sarwar as acting convener?

Members *indicated agreement.*

Anas Sarwar was chosen as acting convener.

The Deputy Convener: I congratulate Anas Sarwar on his appointment.

The Acting Convener (Anas Sarwar): I thank Liam Kerr and my colleagues. I repeat the best wishes to Jenny Marra, who has led the committee well. I hope that my colleagues will continue to be as well behaved for me as they were for Jenny in her period as convener. We wish her all the best with the new arrival.

National Health Service (Leadership and Workforce Challenges)

09:02

The Acting Convener: Item 2 is a key audit themes round-table session on leadership and workforce challenges in the national health service.

I welcome our witnesses and thank them for coming this morning. This is the first in a series of round-table evidence sessions that flow from the committee's "Key audit themes" report. The purpose of the session is to hear directly from those with knowledge and experience of the health and social care sector and to discuss and explore how those recurring issues could be addressed in the NHS.

The evidence session will take place in a round-table format, with the aim of encouraging discussion. As usual, members will ask questions of the participants, but the participants can also ask questions of one another. However, we still want to retain structure to the discussion, so I ask the participants to indicate to me or the clerks if they would like to contribute. When they speak, the microphone will be activated automatically, so there is no need to touch it.

Committee paper 1 suggests two themes for discussion, with some specific discussion points at paragraphs 1 and 9. We will focus first on leadership issues and then move on to discuss workforce challenges.

Before we begin, I ask members and participants to introduce themselves briefly.

I am Anas Sarwar, acting convener of committee and an MSP for Glasgow.

Dr David Caesar (Project Lift): I am deputy director and head of leadership and talent management for the Scottish Government; I am also chair of Project Lift.

Liam Kerr (North East Scotland) (Con): I am an MSP for the North East Scotland region.

Professor June Andrews: I am an independent consultant on health and social care issues, particularly those that pertain to older people.

Alex Neil (Airdrie and Shotts) (SNP): I am the MSP for Airdrie and Shotts. Given that this relates to the subject, I am also a former Cabinet Secretary for Health and Wellbeing.

Angiolina Foster (NHS 24): I am chief executive of NHS 24.

Dr Lewis Morrison (British Medical Association Scotland): I am chair of the British Medical Association Scotland and a consultant geriatrician.

Theresa Fyffe (Royal College of Nursing Scotland): I am director of the Royal College of Nursing Scotland.

Professor Paul Gray (University of Glasgow): I am here today because I was the chief executive of NHS Scotland.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I am the MSP for Midlothian North and Musselburgh.

Caroline Gardner (Auditor General for Scotland): I am the Auditor General for Scotland.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): I am the MSP for Kilmarnock and Irvine Valley.

Carol Shepherd (Medacs Healthcare): I am head of Scotland for a private company, Medacs Healthcare, which has been supplying medical professionals and workforce solutions for nearly 30 years.

Bill Bowman (North East Scotland) (Con): I am a member of the Scottish Parliament for the North East Scotland region.

Dr Donald Macaskill (Scottish Care): I am chief executive of Scottish Care, which is the representative body of the independent care sector in Scotland.

Lewis Macdonald (North East Scotland) (Lab): I am an MSP for North East Scotland. As Liam Kerr said, I am not a member of the committee, but I am convener of the Parliament's Health and Sport Committee.

The Acting Convener: Thank you. The two staff members on my far left are from the official report. On my direct left are the two clerks to the committee.

I ask Alex Neil to kick off the session.

Alex Neil: Thank you, convener, and congratulations on your appointment.

There are two aspects to the conversation this morning. One is general leadership issues as they would apply to any organisation, and the other is specific challenges in the national health service.

I will start with the generality. Since devolution, particularly in the public sector in Scotland, we have had a problem finding the calibre and number of leaders that we need. Prior to devolution, a lot of our leadership talent left Scotland for careers elsewhere. For example, many people in the civil service went to United Kingdom departments that were based in London. Although we retained some high-flyers, we lost a disproportionate number to the civil service in London, because the Home Office, the Treasury or other UK departments were traditionally seen as the best places for civil servants to go for career development opportunities. We have not completely recovered from that. Since devolution, and as the powers of this Parliament have increased, there has been a trend of more civil servants, high-flyers and potential and actual leaders developing their careers and staying in Scotland. However, there is still seepage out of Scotland, because of the attraction of London and what goes on there.

That is a problem in the public sector, but in my experience it is also a problem in the private sector. Few companies in the wider health and social care sector are headquartered in Scotland, and we normally expect to find a private company's leadership at headquarters.

There is therefore still a general problem in Scotland of attracting, recruiting and retaining the high-flying leadership people that we need to run our economy and public services. Specifically in the health service, that is a challenge. We have a relatively big organisation that has within it a large number of other organisations. For example, we have about 22 health boards, 31 integration joint boards and a host of other organisations that support health and social care in the third sector, the private sector and other sectors, such as the pharmaceutical sector.

One of the reasons why the national health service has had so many challenges is that we have found it difficult to find the number of high-quality leaders and managers that we need to staff those organisations. That is not an attempt to insult the people who are in those jobs, because we have excellent leaders in the national health service and social care in Scotland. However, some organisations have got into trouble, and the reason why we are having this round-table session is that a common theme of governance issues, poor leadership and poor management runs through the Auditor General's section 22 reports. Those issues apply to a lot of organisations, including some that are not part of the health service. However, the health service now takes about 50 per cent of the Scottish Government's budget, so about 50 per cent of the reports that the committee sees relate to health and social care, and that theme has been highlighted to us. My first question is: how can we rise to that challenge, and what do we need to do to attract and retain the best people?

Sometimes, when we recruit people from elsewhere, including Scots who are returning, it is difficult to keep them here. It is not always about just the money; it is about family connections and

the opportunities elsewhere. For example, in research and development, there are huge opportunities in the United States, and the opportunities for young general practitioners these days are primarily in Australia. We are competing with a huge world out there. How do we get the best people into Scotland, and how do we retain them?

The Acting Convener: In that very long contribution, there was also a question about whether our organisations in Scotland are structure heavy.

I will start with Donald Macaskill and then I might come to Professor Gray, because he has the most recent experience of leadership in the NHS in Scotland.

Dr Macaskill: With respect, I disagree with the basis of the question. I do not think that Scotland is short of exceptional leaders and or that we have difficulty attracting them, despite the scale and extent of the social care sector. I think that, particularly in social care, we have a crisis around leadership, which has to do with terms and conditions and the fact that 70 per cent of our social care workforce in Scotland is in the non-statutory sector. The nature of that dynamic and the relationships is not always healthy.

In this meeting, we must quickly define what we mean by leadership. Alex Neil described high-flyers. Yes, some of them have flown off, but a lot of them have stayed, and what has not altered is the nature of the nest. We need a different view of leadership.

For me, leadership starts on the front line. It is about the care worker who goes into somebody's house and who is able to, and trusted to, exercise autonomy. At the moment, our systems are not enabling that to happen. It is about the front-line nurse in a care home who is able to exercise her or his ability to make clinical decisions. We are not enabling that to happen, because we remunerate them at an insufficient level.

It is also about the leadership of the social care organisation at the local level and, particularly in an integrated environment, it is about the leadership of the integrated bodies. It is a matter of concern that we have lost so many of our chief officers in the past two or three years. Their ability or capacity is not at fault; the fault lies with the system. The process of integration and the legislation that set it up created a role that is virtually impossible for anybody to undertake. With respect, I posit the view that, in Scotland, we have exceptionally capable individuals, from front-line staff to senior management, but we—the collective "we" in the system—need to enable those individuals to lead, rather than restrict their ability to do so

The Acting Convener: Thank you. You helpfully emphasised the fact that we want our conversation to be focused on solutions. You mentioned pay and conditions and structural issues. What structural amendments are required?

Dr Macaskill: My sector interacts with two primary pieces of legislation. One is the Public Bodies (Joint Working) (Scotland) Act 2014, which created the integration joint boards. Primarily, that is the focus for most care home provision and home care provision. It is some of the most progressive legislation that the Parliament has passed. Nobody disagrees with the vision of creating a single pathway so that the citizen can have continuity of care and support from their first point of contact with the system to end of life.

However, we created a piece of legislation that did not fully appreciate the nature of the dynamic culture change that needed to take place primarily in the two statutory health and social care bodies. We have expected women and men to do a virtually impossible job as chief officers—to be responsible to two masters or mistresses and two systems. We did not appreciate how difficult that culture would be to manage or the power exercise that is at the heart of the system, whether at the local authority level or at the NHS level—that is, the desire to retain authority, power, influence and, primarily, resource. In that dynamic, the third and independent sectors are the children at the end of the queue. That is perverse when we consider that the majority of social care in Scotland is delivered by the third or independent sector. The 2014 act could be adjusted and adapted to make it easier for chief officers to operate.

09:15

The other issue relates to self-directed support. The failure to move forward on the most progressive piece of social care legislation in Europe has been down to lack of leadership, retention of power and failure to engage in the culture change that was necessary to embed that progressive legislation. In social care, that fault lies not with the independent and third sector but with the statutory levels: local authorities and the NHS centrally.

The Acting Convener: Thank you, Dr Macaskill. Professor Gray, now that you are off the leash, do you want to come in?

Professor Gray: Thank you, convener, and congratulations on your appointment today.

I will not respond to everything that has been said, but I will try to answer some of the questions. I am happy to come back on anything that the committee wants to hear from me on.

The first thing is to emphasise what has been said, which is that leadership occurs at all levels. It is hugely important to recognise that. Leadership is not exercised only by chief executives, medical directors or executive nurse directors; it is exercised throughout the system, and we should value that.

Secondly, with regard to structure, it is important to be clear about what is done at five levels—national, regional, local, community and personal—and to ask ourselves whether the problem is structure or understanding. Would structural change help those five levels to be clearer or would improved understanding be the answer to that?

To attract people to the NHS in Scotland, we—pardon me for saying "we", but it is a hard habit to break—have moved substantially in the direction of values-based recruitment, which has produced good results. It has caused us to recruit and appoint a cadre of people who are different from those we might have recruited 10, 15 or 20 years ago. If we are looking for solutions, the values to which we recruit need to be demonstrated in all the interactions that take place. I will be bold, if I may: if, every time something goes wrong and people are transparent about it, the first question that is asked is, "Who is going to be sacked as a result?" what values are we demonstrating? Are we demonstrating the values of willingness to learn, acceptance of responsibility, accountability and transparency, or are we demonstrating a different value? The Auditor General has made good points about that. What is seen in practice?

Thirdly, let us not be so afraid of the prospect that people might be moved around; that is a good thing. If we have one national health service in Scotland—however it is constructed and distributed—the fact that we make best use of the leaders we have in the places where they are most needed is a good and not a bad thing.

Donald Macaskill has made important points about the retention and distribution of power. Sally Loudon and I co-chaired a review on behalf of the ministerial strategic group on progress with integration of health and social care. I was clear that, as the accountable officer for the health budget, my job was not to try to hold on to it but rather to assure myself that it was distributed and used appropriately. Transparency about that and an ability to discuss it openly and fairly is important.

I will also take the liberty of agreeing with Donald Macaskill that more place ought to be given to the third and independent sectors in how decisions are made, because those sectors are critical to this. He imputes a level of unrighteousness to the health boards that is maybe a little severe but, on balance, more scope ought to be given to the independent and third sectors to say more and to have a more direct contribution. The MSG signed off the report, and I think that pressing progress on that is fundamental to success. I could say more, but I want to make room for others.

The Acting Convener: Thank you, Professor Gray. We might come back to you.

Theresa Fyffe: I agree with the point that Alex Neil made about the impact of devolution on the issue, but I would not suggest that it is about high-flyers going south of the border. My job is a UK job. I am director of the Royal College of Nursing Scotland, but I am an executive director of a UK organisation, so I work across the four countries and see the movement there.

Pay is definitely an issue. There is a pay differential between England and Scotland, which makes a significant difference for people who apply. Another issue, which has come as a result of devolution, is that we rightly have a tendency to be proud of what we do in Scotland, but there is also a tendency to take the view that people have to have knowledge of Scotland to work in Scotland. There is an indication that that has changed recently, which is good, but people have thought, "If I go up to Scotland, I won't understand the health system there in the same way," and as a result their leadership skills might not have been recognised as transferable.

The other aspect is the culture—it is more or less the point that Donald Macaskill was making and it is to do with people feeling that they can raise their head above the parapet. Many people here know that we have been talking a lot about psychological safety and wellbeing for all levels, not just for clinical nurses. When we are in challenging circumstances, how the Scottish Government reacts and behaves is as important as how leaders behave. Often, it feels like the pressure makes people go into a behaviour that is not always the best way to demonstrate leadership. I understand that, because I have been in pressurised situations in which it is not easy to keep that balance. However, many are seeking to do that.

I go back to the point about leadership at all levels. For example, not enough value is placed on clinical leaders. We find it hard to recruit senior charge nurses; if we ask nurses why that is the case, the reason that they give is that the day they become a senior charge nurse, they drop their pay, because they do not get the extra pay that they would otherwise get for shift patterns, even though they have taken on a leadership role. That is known but not addressed. I do not blame people on the grade below who earn the same and sometimes more for saying, "Why take that responsibility on for no remuneration?"

However, as was said, although pay is important to how people live their lives and what they want to do, most people are not driven by pay. Most people want a place for values. I welcome the values-based recruitment and the work that has been done on that. It is early days for what that work is seeking to do and we have a long way to go with that. That change is not going to happen overnight. There is a perception that the values that are spoken are not the values that are placed when we are under pressure. The value that is placed under pressure is to get the job done. That does not enable leadership to think about solutions or think differently.

We started off by talking about NHS Scotland, but we now have the integration of health and social care. How do leaders cross sectors? Do we think that the only stable for NHS leaders is the NHS? We have thought that in the past, but do we have to think differently? If people come through one leadership route and they understand the integration of health and social care, could they be a future leader in the other sector? I do not believe that people think that they can be. They believe that there is still a stable that they come through. If we were going to do something differently, that would need to change.

The Acting Convener: You, Professor Gray and Dr Macaskill have consistently used the word "culture". Is culture part of the reason why we have such a high turnover of senior leaders?

Theresa Fyffe: I think so. It is also that it is tough out there in the system. Because I believe in doing this, I have been out on the road a great deal to meet people from all levels who are working hard to do a job. They face issues and challenges. I am trying desperately to remember the name of a particular programme—I am going to use the word "resilience", although I dislike it intensely, because recently, somebody said to me, "You need resilience training, because you are not resilient enough to cope." That is going round Scotland at some staff levels.

Some time ago, we did a programme on courageous leadership—that is the one that I was trying to remember. However, it is not easy to be a courageous leader when the risks that you want to take are not risks that politicians want to take. If you are a courageous leader, you will be told, "That is not a risk that we are going to accept politically," and especially—I have been in this job long enough to know this—"Don't try and take those risks in the year before an election, because the public have a different perspective." The year before an election is not the time to say to people, "Be courageous," because nobody is going to make a significant change then. I have gone through three elections in this job, so I understand that now. To begin with, I thought that that was not real, but now I know that it is. What is missing is the political perspective, as how the Scottish Government and politicians react and behave equally influences the culture.

Angiolina Foster: Like Dr Macaskill, I will offer a gentle challenge to the basis of Mr Neil's question. By that, I mean that I am not persuaded that we have a straightforward marketplace problem here. My own view—and it is a strong one—is that Scotland's public services offer a tantalising thing to senior leaders. Incidentally, I used the term "public service", as distinct from "public sector", in order to include colleagues in the independent and third sectors, both of which are critical in Scotland. Our national performance framework in Scotland is envied by public service leaders in other jurisdictions, because it is right for a leader to put the citizen at the centre of their thinking. When they see that that is the basis of our framework, good leaders are drawn to Scotland. I will come back to a slight downside to that in a moment, if I may. From a leadership perspective, when people are in this game to make a difference, the scale of Scotland—the logistics and the infrastructure—is one that allows them to do that. I am sure that I need not labour that point. Complex tasks can become doable at the scale of Scotland. Thirdly, at the risk of sounding like a VisitScotland advert, the quality of life that we can offer is a genuine component for many senior prospective leaders. Therefore, I am not persuaded that it is a marketplace problem.

However, as others have done, I observe that culture is key. I suggest to the committee that we should be clear and try not to conflate or confuse two things. The first thing is an apparent insufficiency of individuals putting themselves forward, for example, for chief executive officer posts in health and care. Noting that there is a small number of candidates is not the same as saying that there is not the talent, capability, motivation and all the potential that we need in the next tier down. The crucial thing that I ask the committee to reflect on is that people have to choose to put themselves into those positions of extreme personal and professional exposure. What would make them choose to do so? First, if the task that is presented is doable and, secondly—this reflects the comments of other colleagues—if the environment appears to be values based. We say correctly in Scotland that we want values-based leaders. That is absolutely correct. If we say that and mean it, we have to offer those prospective leaders a demonstrably values-based environment in which to operate. We could all reflect on whether, collectively, that is what we currently offer. My third point is to return to the national performance framework, which is undoubtedly a strength in our country.

The Auditor General, the Scottish Government and others have observed that what is needed in health and care is reform and therefore systems-based leadership, by which I mean collaborative leadership that sees the bigger picture and which does not drive a narrow institutional focus.

09:30

My final observation in relation to the national performance framework, excellent though it is, is that the formal accountability frameworks that are currently used to hold the majority of chief executives to account are not yet sufficiently aligned with the outcomes, the spirit and the reality of the NPF. Therefore, in solutions-based mode, I think that there is a very chunky piece of work for us to do as a community to reflect on how we might better align the formal mechanisms of accountability with the excellent national performance framework. If we were to do that, that would bring with it a more attractive environment, in which collaborative leadership was visibly valued and rewarded.

The Acting Convener: After we have heard from Dr Caesar, I will invite Colin Beattie to change the focus of the discussion slightly.

Dr Caesar: I would like to go back to the original question and provide some assurance for the committee. Given what everyone else has said, I would like to provide some data. Part of the Project Lift work that we have been doing since June 2018 involves an active approach to talent management at all levels—in other words, looking for leadership at all levels, as has been described. Nearly 1,500 people have come through that process and have been identified as having high potential, so the supply chain is not the issue. We are actively managing and supporting leaders to come forward into roles, and I agree that we need to do more to support people to get a broader range of experience across public services and across the public sector so that they have broad ability and have practised the very difficult art of collaboration. As many have indicated, we underestimate the testiness involved, and the skill set—the exhaustive listening, the empathy and the emotional depth—that true collaboration requires.

Those skills have not necessarily been viewed as traditional leadership skills; they have certainly not been viewed as traditional management skills. We run the risk of reducing this conversation and other such conversations to something that does not fit the language that we are used to using, so we need to be really thoughtful about how we describe these things.

To give some specifics to Angiolina Foster's point, we are aware of at least 17 people who are one step away from a chief executive or chief officer post in the public sector in Scotland, but fewer than 20 per cent of them would state that their aspiration is to step into a chief executive or chief officer role. It is not a problem with the pipeline; it is a problem with the environment that they think that they might have to live through and what their experience of that would be.

There are many reasons for that. We could easily rush into solutions mode, but we need to take the time to understand what contributes to the culture in senior leadership tiers, and I know that that is the committee's intent. I warn the committee that it will take longer than just one session to get to the bottom of the issue—it has taken me a couple of years to get underneath it. There is a link with the intrinsic motivators for work and what makes us feel fulfilled at work, as Angiolina Foster said.

As Mr Neil mentioned, we are talking about 50 per cent of the public sector purse and, by definition, many of the workforce that we have in the public sector. The issue is having a real impact on our health and wellbeing. If people are not feeling fulfilled at work and are not being well led at work, when they go home they will not give due care and attention to their families or to themselves. We must pay attention to the issue as if it were part of the service that we provide, because it really matters to people. That is what we hear in the system.

I will tell the committee some things that public service leaders have said. An issue that is raised over and over again is a lack of psychological safety. There are many reasons for that, but psychological safety is a key contributor to feeling valued and able to make a difference in roles. Among the issues that people refer to are being punished for creating change, powerlessness to achieve counter-cultural change and talking about kindness but being routinely unkind. Those are things that public service leaders have said.

In a meeting such as this one, the biggest mistake that we might make is to leave it thinking that the issue is someone else's job to fix. We have a collective responsibility, as do many others, to contribute to a Scotland that we wish to be part of. That links to the national performance framework and the aspiration that sits within it. I think back to the recent fabulous care review and what it says about the 15,000 children in care. Why would we not do the same for the 400,000 people who work in health and social care?

The care review says:

"It is clear that Scotland must not aim to fix a broken system but set a higher collective ambition that enables loving, supportive and nurturing relationships as a basis on which to thrive."

That is as true for senior leaders as it is for children in care. We need to work out how we can do that while enabling supportive accountability and holistic approaches to risk, as mentioned in the care review, and how we can all contribute to that, otherwise we might well continue to see a brain drain to other parts of the world. The opportunity is within our grasp; in my humble opinion, we just need to understand our place within it.

Colin Beattie: I would like to touch on a different aspect of what we have been talking about. The Auditor General has reported that NHS boards are having difficulty filling posts. The committee has looked at governance in the NHS—in particular, we have looked at governance in NHS Tayside and NHS Highland. Do you think that the highly publicised situations that have arisen in Tayside and Highland act as a deterrent to people coming forward and taking up leadership roles, non-executive director roles on boards and so forth? Is that a reality?

Professor Andrews: I think that the governance question is absolutely at the heart of this. All the discussion that we have had about leadership so far has been about how we make this business—health and social care—work. We must understand that 80 per cent of what matters in Scotland happens outside health and social care—it happens in communities, and it involves neighbours and people looking after themselves and just living their lives.

I am reflecting on what Theresa Fyffe said about difficult things not being done before elections and on kindness, because some of the things that we should be saying about the business are unkind. We are talking as though the people around this table are the managerial board of the business, but the most important thing that elected representatives can do is something at a strategic decision-making level in relation to what is going to happen in Scotland.

My knowledge base is mainly in the care of older people and, in particular, older people with dementia. Even when, ages ago, I was working in the NHS as a director of nursing, we kept seeing the graph that shows that wedge of older people coming towards the system. Even today, we have hospitals in Scotland in which 92 beds, say, are occupied by people whose discharge has been delayed because they are old and frail and they are not managing to get out of the business whose management and leadership the committee is discussing. In a curious way, we should not be discussing how we find people who are prepared to do this unmanageable task; we should be talking about the upstream, strategic things that we should be doing to make this no longer the broken wheel that people keep trying to turn. No one would want to have any responsibility for this task because, in many ways, the task is undoable unless we have some real strategic change.

As a nurse, my job is to be kind, but I also rip off sticking plasters. Sometimes it seems unkind to say what has to be said. I have two or three sticking plasters to think about today. At the moment, there is a lot of bad reporting in the news about a pandemic. For someone who is on the board of a care home company, a pandemic is one of the things that they will think about as a potential cause of damage to their business because of the number of older people that it will take out of the system. Curiously—ripping off the sticking plaster—in a hospital that has 92 delayed discharges, a pandemic would be quite useful because then the hospital would work, because those people would be taken out of the system. That sounds like a horrific thing to say, but it is the case that, somehow or other, we have put people in the wrong places by not having the kind of strategic views that we should have.

That means that politicians, who do not want to think about bad things just before elections, need to think about putting income tax up even higher in order to pay for more care in care homes. They need to think about whether to reinstate geriatric hospitals—I am sure that it would be possible to build a geriatric hospital. They need to think about the ambition for everyone to have their own room or their own en suite facilities in hospital. They need to start to think about different ways of looking after people. You cannot have your cake and eat it—you cannot have the current levels of public finance, people in jobs trying to make it work and your policies on ageing. I am not saying that we should go as far as China has gone with filial responsibility laws that say, “The families should do it.” Rightly, the emphasis these days is on supporting carers rather than putting a bigger burden on them, but at what stage do we tell people that, because of the way in which we have organised our politics, they will get that burden anyway? At what stage will we tell the people who are running the hospitals and care services that they will get that burden anyway?

In some of the appalling boardrooms that I might have been in, I have heard it said, “Another thing that might be a danger to our business is euthanasia.” There comes a point when a decision has to be made between the adverse situations that happen in the lives of the workers and the people who require healthcare, and the policy decisions that people are not making about increasing taxes, having new systems and telling the public that they are on their own—exit sticking plaster.

Dr Morrison: To respond to Colin Beattie’s question about whether adverse publicity about

what has happened in specific localities puts people off, I think that the issue here is endemic and widespread. I think that health boards that have not been the subject of such publicity are probably thinking to themselves, "Well, at least it wasn't us." I am not absolutely convinced that specific localities become unattractive. We have already talked a lot about what is a pervasive culture and, as Dave Caesar has said, it is beyond our powers to get into the reasons for that in an hour.

To build on something that Theresa Fyffe said about people exposing themselves, there has been a massive conflation of leadership and management. That happens all the time. People often assume that when they are put in a leadership position, they are there to manage those whom they have been put in charge of. For me, that is the cultural issue, particularly in the NHS. Management is no longer enabling—the instructions come down the way from management, rather than management providing help to those who are under their care.

To come back to what Professor Andrews said about care of the elderly, the question for me is a fundamental one: what are our health and social care services for? What is the need? Have we got that right? At the moment, we work in a system in which, in an effort to tie this together, those who lead and manage are asked to deliver particular things on behalf of health and social care. We have not really talked about targets so far this morning. We need to ask whether the targets are appropriate. After the winter that we have had, and with the prospect of a coronavirus outbreak, it strikes me that there is potentially a big mismatch between the things that the NHS is being asked to deliver—which those who lead the NHS must deliver on and are accountable for—and what the health and social care needs are.

09:45

I think that if we have a significant viral outbreak, one of the ill winds will be that it will teach us some hard lessons and some very important things about our services, which we must learn from. It is easy to be a bit catastrophist about what might happen. None of us in this room has a crystal ball—we do not know how coronavirus might play out—but many of the issues that we are talking about this morning will be writ large in the next few weeks and months. It is vital that we learn from what happens.

To come back to what Dave Caesar said about identifying and nurturing leadership, we need to accelerate that work, because too many people at what I would describe as middle managerial level find themselves colossally exposed when they are promoted. Coincidentally, we interviewed for a new charge nurse on Tuesday, and it is at that level that people are afraid to take the next step. They are afraid of being exposed, because they have not been trained. There is a lot of talk about whether leaders are born or made. That is simplistic. I think that, in general, leaders are trained, but they must be given the tools to do their job. The job that they are asked to do must be doable, and it must be the one that the public and patients need, not one that is dictated in an artificial way.

The Acting Convener: I do not want to curtail the discussion, because it has been really great. We will have about five more minutes on leadership challenges and then we will move on to broader workforce challenges.

Bill Bowman will change the focus on leadership challenges slightly.

Bill Bowman: Before I do that, I would like to follow up on what Dr Caesar and Dr Morrison said, which was interesting. Mention has been made of the pipeline of people coming through, but I think that, by definition, a leader must be someone whom people follow. Dr Morrison dismissed the idea that leaders are born and not made, but I think that people must have something in them that makes them want to lead—they must have the ambition to want to do that. I do not know whether that has come through in what has been said.

Dr Caesar: We cannot do justice to what leadership is in such a short session, other than to say that it is highly contextual, and we now understand that it must also be highly social. Leadership must mirror the needs of the society in which it operates and the system in which it operates. That is why we see so many different styles of leadership.

To respond specifically to Mr Bowman's point, of course motivation/ambition is a key part of that, which is why it is one of the four domains in the leadership profile that we are looking for. It is a very generic leadership profile that includes ambition, ability, values and insight, all of which are important and which all of us have to varying degrees.

It is true that leaders should have the ambition to make a difference for the service that they lead. They should perhaps also have the ambition to serve the people they lead. The issue of leadership and followership is one that we could perhaps debate at another time.

There is no doubt that what we have learned in undertaking the work on Project Lift—this links to the point about values-based recruitment that others have made—is that, if you are not doing a formal leader role in which you manage other people, which Lewis Morrison was hesitant about,

there has to be a strong core component of service. Leadership that involves a strong element of service is what people need now. That is often what makes a leader demonstrate leadership. It is a fundamental component that is wrapped up in the values statement, and it comes out over and over again when we speak to people.

Ambition is necessary, but we need to make sure that that ambition is pointing in the right direction.

Angiolina Foster: In response to Mr Bowman's question, I think that part of the material disincentive at the moment for prospective leaders with ambition in Scotland is the fact that—this is rooted in the observations in the Auditor General's report and in a number of the Scottish Government's papers—the current construct in health and care is not sustainable. The current service models require reform. The unspoken message to prospective leaders at the moment is that, if they could only find some sixth gear to run in, with wonderful leadership and ambition, the current construct could somehow, with them at the helm, be rendered sustainable, but that is simply absurd.

Collectively, we must adopt a shared narrative that acknowledges the need for system reform, and we must define the core role of the leader as being to do the best for our citizens under the current construct and within the existing constraints but, at the same time, to redesign our healthcare system in Scotland in such a way as to render it better for the citizen and, ultimately, make it affordable and therefore more sustainable. That is a hugely attractive job description for our pipeline.

The Acting Convener: Bill Bowman has a brief question about lessons to learn.

Bill Bowman: What can the NHS learn from the related private, independent and third sectors about how to address the leadership challenges that it faces?

Dr Macaskill: As Dave Caesar has already said, where relationships, communication, engagement and collaboration are evident, we see integration working at grass-roots level, we see leadership working in organisations and we see a collective shared vision and a determination to achieve it. However, as Dave Caesar has highlighted, those do not come easy. At the moment, in home care in the third and independent sectors, we are stripping learning and training and development budgets out of commissioned contracts by up to 18 per cent. We are not going to develop leaders who can talk, share, listen and learn if we do not train them. That would be our lesson to the statutory service and sectors: listen, learn, share, collaborate and—dare I say it?—ask.

Professor Gray: I think that Mr Bowman asked what we can learn from elsewhere. One of the things that I have learned from working in the public sector and, now, the private sector is that leadership is hard everywhere. There is no simple solution sitting out there such that, if only we used it, everything would be fine.

What I have learned from the private sector is that making sure that people are clear about their focus and then not distracting them from it is a good thing. The trouble with the public sector, of course, is that things can change very quickly indeed. What I have also learned is that a motive that is exclusively based on making a profit does not motivate people all that much—they need a bigger context and something more worth while. Whether we call it values or something else, people need something worth while to do. If they do not think that it is worth while, they will get bored and frustrated, and they will eventually become demotivated and go and do something else.

Pretending that the private sector is very bad and the public sector is very good is nonsense, but pretending that the public sector is dreadful at everything and the private sector is wonderful at everything is equally polarised nonsense. A willingness to learn from the best that we can find everywhere is hugely important.

The values of the public sector remain hugely important to me, so I want to continue to subscribe to them. However, I also think that we should be a little more straightforward about the fact that there are some things that the private sector does rather well—for example, I have no intention of trying to generate my own electricity or build my own computers. We live in that world. Let us take advantage of the best that everybody offers, retain the values that we have and ensure that we are transparent with the public about everything that we do. Learning from everywhere is better than learning from nowhere.

Carol Shepherd: I agree with just about every point that Paul Gray made.

I am from a private sector company that has been in healthcare for about 30 years. We will go in and help to find workforce solutions. As a private company, we face the same challenges with leadership. We, too, get the experts in to help us with our training and development. We recently introduced a promise-based culture, from the leaders all the way down. We have learned from that that, if people do not have the time to be able to reflect and to have the conversations that they need to have with everybody around them so that we are all on the same page and are all working

together and working collaboratively, the learning and the investment stop there. It must trickle down to everybody—it cannot rest with one person. One person cannot make or break a board, a business or a company.

When I read the key points for discussion—this is my first time attending such an event—my first thought was that, in our business, if we were asked about the possible reasons for the high turnover of senior leaders, we would pull together all the extensive exit interviews that we had held and would look at the proactive recruitment efforts that we had made. We would ask what conversations we were having with the leaders we were trying to attract; we would want to find out why they did not want to come. We would be gathering all that information together and having it readily available. I apologise if that information is already readily available.

We have worked with many health boards and trusts, and we find that the biggest challenge is the culture and the fear of change. There is a fear that we will come in as a private company and tell people how to do their job. People are worried that they might lose their jobs, but we are there to provide expertise. Ideally, we will then move out and people will be able to carry on.

I have an example of that with NHS Lothian, with which we work closely. It engaged with us on the provision of temporary staff. NHS Lothian made it clear to us that it was getting us in so that it could learn from us and that, once it had learned from us, it would manage the situation itself. That is exactly what happened. NHS Lothian got us in and it extended the contract, because it wished to learn about another part of the business, which it wished to take away from a third party. Currently, NHS Lothian is the only board that manages its own direct engagement for the temporary supply of medical locums. That takes away the cost of third parties. It invested in that, it spoke to the experts and now it is putting that in place.

Therefore, learning can take place in both directions. However, Mr Gray is right—the same problems are faced in the private sector as are faced in the public sector when it comes to leadership and attracting the best talent.

The Acting Convener: Thank you. It has been a fascinating conversation. I deliberately let that part of the discussion run over time, because the contributions were first class. That means that we will have slightly less time for the second part of our discussion. Every person who spoke mentioned culture, so it is clear that that is a recurring theme. There are also issues to do with skills training and pay and conditions. Let us have a conversation about structure and how we get a better understanding of structure. However, we could probably discuss those issues until the end of time.

Alex Neil: Can I ask a quick question?

The Acting Convener: As long as it is very quick.

Alex Neil: One of the key points that David Caesar made, which is one of the key points to have come out of the conversation, is about the number of people in the pipeline who are taking the training but who will not take the final step and apply for the top jobs. The figures that he gave were very worrying indeed. Why do those people not want to apply for the jobs for which they are being trained?

The Acting Convener: I ask Dr Caesar to resist the temptation to answer that question just now. I will let Willie Coffey introduce the workforce challenges part of the discussion, and perhaps Dr Caesar can wrap the answer to Mr Neil's question into an answer to Mr Coffey.

Willie Coffey: I want to widen out the discussion to broader workforce challenges. Carol Shepherd led us in that direction a moment ago.

I ask this question with some trepidation, given that I am sitting next to the Auditor General, whose report told us clearly that we face significant workforce challenges.

A quick look this morning at the NHS Scotland recruitment website shows us that there are 1,380 vacancies in Scotland right now, over half of which are in four health boards—Glasgow, Lothian, Grampian and Fife, although the number in Highland is also quite high, at more than 130. On the types of posts that we are looking to fill, nearly 500 are in nursing and midwifery and more than 300 are GPs and dentists, which comes to about 800 vacancies. What is going on in those areas? Why are we finding it difficult to recruit and retain? Is it to do with pay—with salaries? It was concerning to hear earlier from Theresa Fyffe that some people do not want senior charge nurse jobs because they lack confidence—or perhaps because they would get paid less than the staff they would be supervising. We have to explore that a bit more. Are the issues about leadership or about location? I throw that question out to get some views from the panellists.

10:00

Professor Andrews: I hope that, on this occasion, my contribution will be quite brief. I was on the workforce commission that did its work last year, when we spent a lot of time thinking about those things. It may have felt as if I did not answer Colin Beattie's question about what we could learn from the health boards that he mentioned, but what I was trying to say is that we have learned

that the job is impossible—that is the sort of thing that we have learned.

To go back to Mr Coffey's question about why it is difficult to recruit people to those jobs, my answer again would be that it is because the jobs are impossible. We need to make a plan for a future in which it is possible to do health and social care. At the moment, we are not really thinking about what we have to do in order to make health and social care work in the future. We know what the population profile will be like, we have some idea of what finances we will have available, and we have some power to increase or decrease the amount of money that is available, but we also have some cultural changes to make, and that includes in relation to things such as the extent to which families are responsible for the care of their older relatives.

Again learning from other parts of the world, as Professor Gray says, in some places, people recruit low-cost, unskilled overseas workers who live in the house and look after their older relatives. Clearly, there are all sorts of reasons why that is not acceptable here, although we recruit low-cost overseas people to work in our public services and care homes.

To be brief, there is a whole range of things that we have not addressed about the future shape of services and what we are going to do. We keep focusing on how we keep this broken wheel turning rather than thinking about the big picture and what we should have in the future, when it will be easy to recruit people because the job will look possible, as we will have properly costed it and will have outlined what the health and social care services in all four sectors will do and what will be left as the family's responsibility.

Some of the options seem really unpalatable, because they are not like our culture. Where does housing come in? Are we going to build multigenerational houses so that I can look after my father in my house? Are we going to build the sort of houses where, if he becomes incontinent, I will not have to worry about whether the toilet is upstairs? There is a whole range of issues.

I apologise to my father, who is perfectly well—that was a hypothetical dad.

Theresa Fyffe: There is no question but that there is a significant staffing shortage in nursing in Scotland. A number of variables influence that. Nursing is one of the largest workforces in the NHS in Scotland and now within the integrated health and social care space, so the budget is significant. I have watched a cycle of investment in nursing, disinvestment in nursing, investment in nursing and disinvestment in nursing. As a result, there is an eventual impact on how many people stay in the profession.

The senior charge nurse example that I used earlier has been a long-standing issue, and people are not heard on it because we are very fixed on the systems that we use. The process whereby your salary is gained from the shift patterns that you work meant that, when we decided that we needed senior charge nurses to work from Monday to Friday, which was appropriate at the time—I was part of the system that did that—they got less money, and we did not pay attention to that.

However, it is much more about the culture. I have been out on the road and spoken to people who said that they have spent time trying to persuade those in other grades to go for senior charge nurse posts and asking "What's happening here?" It is the psychological safety and wellbeing that is affecting them; it is not just the pay. A lot of them really love the job that they do, but they feel that they cannot carry the responsibility and the burden.

One thing that I have learned from watching when things go wrong is that there are distinct differences between areas. If you live in the area where you work, you are part of the community, so you feel responsible for the service in a very different way. I learned that in Grampian, when they went through what they went through there. The nurses I spent time with said, "It's our hospital," or "It's my family's hospital." When they leave, they go home to face family and other people who will be critical of what they do. I saw that in other areas, such as Fife, where I spent time when there were challenges there. In a bigger place such as Glasgow—I was there last week—most people live somewhere different from where they work, so, even though they will be challenged, they do not have that sense of community or value about the place where they work.

We rightly invest in agency and bank nursing, because we will never have a system where we do not need that. However, costs are rising in agency and bank nursing to an unsustainable level.

When I was in Glasgow last week, I was told that they are struggling to recruit. That is partly because of the pension changes that have come in, which made a significant difference to the workforce. We did not see that coming and, when it happened, many people retired—they are the people whom we will be after very shortly—but they have actually gone back to work part time.

Two days ago, I was in a meeting in Orkney, where one issue was maternity leave among a workforce who are all young and female—goodness knows what was going on up there, but they are all going on maternity leave, so that is a significant crash for the system. The other issue is that of people who are retiring in the next year. I

asked what retiring meant, and everyone around the table was unanimous in saying that it meant leaving the system but coming back to work as they would like to work. They were all in the 50 to 55 age group. We have a drain in Scotland at the moment on that age group. They want more flexible working and they want to be able to enjoy what they do. I was bothered by the message that taking on a clinical leadership role or a managerial role was too much of a burden. People were saying that they did not want to do that; equally, they were saying that they wanted to see people coming through.

I would like much more value to be placed on clinical leaders' decision making, because I believe that the balance has gone in some places. People are not being heard or valued, and then we get the language of clinical versus management, which I do not like and I think is wrong. Management are trying to do their job, and it should be about collaboration and, as Dave Caesar said, team working, and not about them and us. There is still a bit of that culture around, and it is very damaging to how people go forward.

The Acting Convener: I have a couple of quick follow-ups on that. Do you think that, rather than turning to agencies, we should expand and reform the bank system to make it more flexible for people?

Theresa Fyffe: The boards have done some excellent work on trying to get a bank system that reflects that flexibility. I see why people choose to do bank work. We will never remove agencies, because bank will never cover particular specialisms. You could never have enough for some areas. You would always have to rely on calling in an agency if you were short—theatres is an example, although national work has been done in Scotland to try to manage the theatres issue, which is the right approach.

However, that solution is not the answer. We should not keep investing and disinvesting. At the moment, we are increasing nursing numbers, which is great, but the other day someone said to me that we need to stop that now, because it will cost more. We are a large workforce, so people spend more time thinking about how we can get more out of that workforce by changing it, and that does not make people in the workforce feel valued. That does not mean that they do not think that there is a place for a skill mix—they do—but they understand that the expertise of those who are clinical leaders needs to be valued as well. In many places, people do not feel that it is valued at the moment.

Dr Macaskill: Undoubtedly, the biggest challenge facing the social care sector in Scotland, whoever provides that care, is workforce. We have major, and potentially catastrophic, issues around recruitment and retention. The independent care sector, which has 67 per cent of the total social care workforce, is probably reflective of others. Nine out of 10 of our providers are struggling to recruit to vacant posts. Theresa Fyffe referred to nursing. One in 10 of Scotland's nurses work in the social care sector. We have an average vacancy level of between 25 and 30 per cent, but in some parts of Scotland, particularly the north, that goes up to more than 40 per cent. That is simply unsustainable.

There are various reasons for that. We are sitting here in Edinburgh. If you had looked at a certain newspaper last night—I will not mention its name—you would have seen an advert for a job as a dog walker in Edinburgh, paying £17 an hour. Alongside it, you would have seen an advert from a well-performing independent care sector home care provider offering £12 an hour, which is still more than the average Scottish living wage of £9.40 an hour. We cannot delude ourselves any longer that, in Scotland, we are not trying to purchase care on the cheap. There is no other argument for the way in which we commission social care services. The United Kingdom Homecare Association has evidenced independently that the rate should be around £21-plus an hour for quality commissioned home care, but in parts of Scotland, a provider in the charitable and independent sector is still being paid £15.45. We are deluding ourselves if we think that it is possible to recruit and retain the best if, frankly, we are paying peanuts. That is one factor.

I commend the work of Professor David Bell from the University of Stirling, who submitted to the Health and Sport Committee and who has analysed in real depth—probably for the first time in Scotland—some of the social care gaps. He refers to the fact that the national statistical body has highlighted our lack of social care data. He also argues that we will need around 20,000 more social care staff in the next 10 years and that we will need to triple the amount that we spend on social care provision. It is a very thorough piece of work.

We are deluding ourselves if we think that we can continue to keep the system going at the present rate. Most of the workforce—86 per cent—are female, and the majority are over the age of 45. The majority are choosing to leave the sector.

There are additional elements. We are overregulated. The process of registration and qualification is driving people, particularly experienced women over 50, out of the care sector. We have been inflexible in the adoption of new registration criteria. We need to take seriously the fact that, from the end of this year, the proposals of the Westminster Administration will massively impact our ability to recruit individuals

from outside Scotland. In social care, we are massively dependent on our international workforce. The immigration proposals will be cataclysmic, because they will shut that door.

I could go on, but we must start to be honest that this is a whole system, and if social care disintegrates, as it might very well do if we cannot recruit, the NHS will follow the next week.

Dr Morrison: In many ways, what I am going to say echoes what Dr Macaskill said. To come back to the original question about the numbers that we are short of, Dr Macaskill talked about honesty. A vacancy is seen as a vacancy only if you are looking at that moment. The real question is how many bums are not on seats. Consultant vacancies came out this week—my colleague Graeme Eunson did some media work around that—and we are still not being honest about that. It is a snapshot and, if it is the day after and you failed to get any applicants for a vacancy, it does not count as a vacancy.

Then, in a double whammy, when the response to that is the message that Scotland has more doctors, nurses or whatever than ever before, that is quite demotivating—and not just for me as the leader of a professional organisation. It is demotivating at individual level for people to be told, "What are you complaining about? There are more of you than ever before." That is not the point. The question is how many we need now, next year and in five and 10 years' time.

We have never managed to find the holy grail of workforce planning. I have been through about four or five workforce planning processes in my time in medical politics. Some of them have worked better than others but, to be blunt, none of them has really worked. The reason is that we are chasing the tail—we are always trying to fix the now and, because we are so busy trying to do that, it is very difficult to plan for the future.

10:15

The question is why there is a recruitment problem. Money matters. Compared to the salaries that many social care workers are paid, it is difficult to talk about senior doctors' salaries and sound credible, because they are higher, and that is for lots of reasons. However, we are taxed more in Scotland, and public sector pay policy limits the pay of senior doctors in Scotland. From a personal perspective, there have been years when I had the lowest percentage pay rise, in return for my 25-plus-year commitment to the service in Scotland.

There are important messages there. People are retiring early because of a tax system that means that they have to do that. We have mentioned the burden of regulation. There is the drip, drip, drip of 500 emails a day—sorry, it is probably more like 50, but you know what I mean. It is about trying not to drown in your clinical workload and then realising that your appraisal and revalidation are a few weeks away and you just have not had the time to do them. There is a cumulative burden.

I try not to use anecdotes, but I am sitting here today wondering when my radio pager is going to go off. We have four junior doctors in my unit but today I have one. One of the reasons for that is that the recruitment system that was meant to send us four GP trainees over the year has sent us one. That recruitment system has no responsibility to help us backfill. The consequence for the service of the failure to recruit impacts on me as an individual consultant, and I do not have the powers to fix the issue.

That is the situation that we find ourselves in today. I would not be here if that junior doctor had not turned up today, because I would have had to go to work and be my own junior doctor. That is the situation that we are in now. The real vacancy rate is what is happening on the ground now. We need to be open and honest about where we are. We then have to ask ourselves where we are going and what health and social care services are for. That requires an honest conversation with Government, and real action, not just to improve pay and conditions but to make people feel that they are valued.

Carol Shepherd talked about exit interviews. Five years ago, in my unit, I was the last man standing, because two colleagues had just had enough and left. Were they asked a single question about why that was? No—they were just allowed to leave. We are kidding ourselves if we think that we are in a decent position at the moment. To get from where we are to where we need to be, we need to do more than just complain about it; we need to say honestly what we need, and then enable people and give them the tools to fix the problems that they have. I have no tools to fix the problems that I have in my unit today.

The Acting Convener: Will the service that you have in 10 years be the same as the service that you have today? If you do not know what the service will be in 10 years, how can you adequately do workforce planning for the future?

Dr Morrison: That is a very good question, and there are probably two answers to it. First, there is what I believe the service should be. I am, I hope, probably about 10 years away from retiring, so I am at the stage in my career when I am starting to think about what will come after me and what the service will need—and whether it needs another me.

There is a separate question about what will be available, regardless of what I think. There is often

a mismatch between what professionals know is required and what they know they can get. A lot is said about service reconfiguration and where we are delivering care: we are changing to care being not so focused on buildings, but more on the individuals who need the care. However, we cannot pretend that we do not need the buildings, the beds and the people. We must not pretend that change will make everything better. There is a fundamental question about what we are trying to do.

The Acting Convener: Do we have a credible workforce plan for the next 10 years?

Dr Morrison: We do not have a workforce plan. We have a plan for a plan, but no plan.

The Acting Convener: Dr Caesar?

Dr Caesar: Thank you for that hospital pass. It would be remiss of me not to mention that the integrated health and social care workforce plan is uniquely challenging to produce. As Donald Macaskill said, we are talking about a highly complex and interdependent system that extends, if it is about health and wellbeing, beyond healthcare and social care. Even just grappling with that is a really important starting point.

I return to Angiolina Foster's point about the national performance framework. We are uniquely placed to start making real investment in consideration of how we approach deep-rooted and fundamental questions about what we are there to do, where the boundaries are and how we can soften them to enable us more seamlessly to keep our citizens healthy and well. We have a genuine opportunity to shape that.

Workforce planning is uniquely challenging. There is an absolute commitment to try to make it as good as it can be, as members will have seen in the integrated workforce plan, but it will not be perfect, because such things can never be perfect. Many externalities, as one might put it, will come down the line, and there is a lag period in training medical nurses and other healthcare professionals, and in training other professionals who are not directly healthcare related. Significant time and investment are required for that, so it will, by definition, be really difficult to get it absolutely bang on. However, the intention to do that definitely exists.

I will go back to Mr Neil's point about why people hesitate to step into senior roles. Such things are complex, as many people have stated. We do quite a lot in trying to broker people's stepping up, or stepping diagonally, so that they can move up the tree again. We in Scotland are uniquely well placed to do that. It is very difficult to do it in England and other places that have similar systems.

Many factors that have been touched on come into play. They include the person's family situation, the team in which they will operate, their level of autonomy, the training that is available, the opportunity that might follow, and the level of accountability and scope of responsibility that they will experience. There is a range of issues that are about capability in its broadest sense. As Lewis Morrison said, decisions are based on what the person will be free to do and be able to do in post, rather than on what the job description says. They will consider what resources they will have to play with, including the resources that they will bring and those that will be available to their team, their line manager and their organisation.

Such consideration is at the heart of what people are experiencing at the moment. We talk about workforce numbers as being the thing that we need to fix. We need to do that and to understand what we need to put in place and plan for in the future, but we also need to understand the workforce numbers and the burden of work.

As has been said, much of that is not necessarily directly related to delivery of care, but to the assurance of delivery of care, and to defence of how care has been delivered. There are a number of examples. The infrastructure that is associated with scrutiny, assurance and accountability—which are all important—has a burden that is felt at every level in the public sector and in independent social care providers.

We need to understand the reality of work for people—it varies, so there is no single answer—and how that impacts on our taking a numerical approach to workforce planning. Angiolina Foster made the point that we must consider what we need to do and how we can use all the assets that are in play to deliver a healthy and well nation. We need permission to do that and we need to invest time in it. At the moment, we do not create space even to get under the surface. We are putting a finger in the proverbial dyke, but not working out where the water is coming from. That is what I encourage the committee to work on.

The Acting Convener: The new, and very delayed, "An Integrated Health and Social Care Workforce Plan for Scotland" was published in December 2019. We have heard from Dr Macaskill and Dr Morrison about whether it will address concerns. Professor Gray was involved in drawing up the plan. Do you have any reflections on whether it will address current concerns?

Professor Gray: We should acknowledge that folk are trying to do that. There are not clear binary responses to the question. Is the plan perfect? No. Is the fact that it exists good? Yes. Is the fact that it is prompting debate good? Yes.

Let us seek agreement on what can be done and not merely discuss what is not being done. One of the most important lessons that I have learned as a leader is that something that is 70 per cent good is a lot better than something that does not exist, so let us try to build on what exists.

I will make some very brief points. Mr Coffey asked about, and Lewis Morrison referred to, vacancies. Transparency about the vacancy situation is hugely important. A system that has no vacancies is a static system and is therefore likely to be dead. Therefore, having some vacancies is good, because it shows that there is turnover, flexibility, ability to recruit and so on.

However, a vacancy that has been unfilled for two years is very different from one that has been unfilled for two weeks. It important to have something that shows what posts are apparently impossible to fill. In trying to recruit to a specialism that is internationally under pressure, the fact that you have a post might be utterly irrelevant: if there are 10 people who do the job and they are all employed elsewhere, there is not a person to recruit. We must therefore think about the types of roles that we are advertising.

My second point is slightly tangential. In this country, people who look after small children and elderly people are among the lowest paid. We have talked about values and culture: what does that say about our values? I am not saying that money is the only way that we can express value, but the fact that the jobs that are deemed to be worthy of least remuneration are those that involve our most vulnerable people says something. I suggest that the committee reflect on that.

Thirdly, in the system that we have discussed, people's lives are being saved, and people's wellbeing is being assured. In the past month, three of my relatives have had their lives saved or greatly enhanced by the health and care system.

Let us not forget that a lot that is absolutely outstanding is going on: I do not want folk who work in the system to listen to or read about today's discussion and think that the system is completely broken, because it is not. There are elements that are not working as they should, elements that need improvement and elements that need to be ripped up and replaced. I do not dispute any of that. However, this morning, people—I will not name professions because, doubtless, I will miss one—are working their hearts out to keep other people alive. We should commend that.

Finally, I would like to ask the Auditor General a question—if time permits an answer and you allow it, convener. The question is simple. Does she recognise what we are saying? Is the system that we are talking about what she sees from her perspective, or are we missing the point?

10:30

The Acting Convener: Auditor General, I ask you to resist the temptation to answer, because I will ask you to wrap up at the end of the session with your reflections.

Professor Gray, I would emphasise the point that you made about NHS staff, which was well made.

Lewis Macdonald, who is the convener of the Health and Sport Committee, has a question.

Lewis Macdonald: I have listened with a great deal of interest to what has been said today, some of which I recognise from evidence that the Health and Sport Committee has taken.

Workforce planning continues to be a concern and, along with Paul Gray, I have a specific question for the Auditor General, the answer to which I am sure she will be happy to wrap up with her other answers. We have heard workforce planning described today as

"a plan for a plan",

rather than as the kind of planning that is required. She has commented on the need for effective workforce planning, so the Auditor General's take would be interesting, despite the small number of weeks in which she has had the opportunity to look at it. It would also be interesting to hear from other witnesses what they think is required to transform the "plan for a plan" into an effective workforce plan that allows us to look five or 10 years ahead.

The Acting Convener: Before I let the Auditor General in, I note that we are now over time. If any other witness desperately wants to respond to Lewis Macdonald, I will allow them time, if they are brief, although it appears that nobody else has a point to make.

The Auditor General has obviously looked at the issue in a lot of detail. For obvious reasons, you have sat back and listened to today's fantastic contributions. Perhaps in your reflections on those contributions, you can also pick up on the direct questions that were posed to you by Paul Gray and Lewis Macdonald.

Caroline Gardner: I will do my best, convener. I completely agree that it has been a fascinating conversation. It has been a rich and—to use the words that Dr Morrison used—open and honest discussion.

In response to Paul Gray's question, I note that what the witnesses have said today reflects what we have been reporting for a number of years, but

it has added to it texture, colour and real-life experience, so it has been a privilege to be here.

On Lewis Macdonald's question, we have been clear that workforce planning is complicated and difficult, and that it is not just a numbers game. It needs to take account not just of the professions and roles that we have now, but of those that we will need in the future, in the context of our changing population and the pressures that that will bring. It must also take account of the changing expectations that we all have as we move through our lives and as the world around us changes.

As Angiolina Foster said, we need also to think not just about what the NHS and healthcare can do, but about what Scotland as a whole can do using the other assets—if I can use that term—that we can bring to bear. They include communities, better education and early years services and all the things that the national performance framework aims to pull together to make us healthier individuals throughout our lives, and to make our society a more resilient one that can support people better. It is not easy, and I agree that the current plan does not yet do enough of what is required.

Paul Gray was right: there has been progress, but the plan does not help us to decide which of the people who are coming into the workforce now we should be training and developing. It also does not help us in respect of how to make their jobs more doable, and the system more effective for the longer term, for nurses and doctors such as those who are deciding that the game is not worth the candle and they cannot do it any longer.

As I have listened to today's conversation, I have noted a couple of things that I want to say. I am grateful for the opportunity to do so. Theresa Fyffe talked about the importance of the political context and the electoral cycle, which has become clearer and clearer to me during my time in this job. I have had the experience of publishing our annual report on the health service on a Thursday morning, and chatting to Opposition MSPs in the Parliament's garden lobby who have said openly to me that they get what a big problem it is and that it is impossible to close a hospital or change the way in which out-of-hours services are provided because of the political pressure that is put on the Government of the day. I have then tuned in to First Minister's question time at lunchtime and heard those same people throwing brickbats at the Government. I recognise that that is a function of the political context in which we work, but it is important that we recognise that that is a major barrier to the changes that we are talking about.

The small things that happen and the symbols that people see around the system really matter. We all know about the things that have happened in NHS Greater Glasgow and Clyde over the past wee while, in NHS Lothian and—as the committee knows—in NHS Tayside and NHS Highland. The way in which people are treated by Government and Parliament in such circumstances has an effect that goes well beyond the handful of people who are named in the papers or who sit in front of a committee. That is important.

I will finish on a more hopeful note. We know that some of the difficult things can be done. We have reported repeatedly on health over the past few years, and we have reported a couple of times on social security: there are some real similarities. Although it is much smaller at the moment, the social security system will affect the lives of the most vulnerable people, and a lot of money is being committed to setting up the system for the longer term.

One of the things that we have reported on is how well the Government has lived up to its commitments to prioritising dignity and respect, to designing systems that are different, to involving people in designing those systems and to having checks and balances that ensure that those people's voices are part of the system. The staff who are delivering on those commitments—in Government, through its programme, and in the new social security agency—are working flat out in high-stakes, high-pressure circumstances. They are delivering information technology systems—which the committee will know all too well can go badly wrong—and, so far, are doing so very well and in a well risk-managed way.

I would reflect on what we can learn from what has been done in social security and apply that to a much bigger and more long-standing set of public services in health and care—how we can take some of the great things that have happened and translate them in order to build on the work that people in this room and much more widely are doing every day.

The Acting Convener: Thank you. I repeat our thanks to all the witnesses for their evidence today. It has been a fascinating conversation that has been reflective and honest. I think that we all want a health and social care service that is fit for our times and for future generations.

I restate Paul Gray's point that we are lucky to have a phenomenal health and social care service, and we send our thanks to all our health and social care staff who do life-changing and life-saving work every day. It is because we appreciate and love our NHS that we want to make sure that it is sustainable and continues to grow and get better.

We will now consider the discussions that we have had today in relation to next steps for the committee.

10:37

Meeting continued in private until 11:34.

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