OFFICIAL REPORT
AITHISG OIFIGEIL

# Health and Sport Committee

**Tuesday 27 September 2016**

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

# Tuesday 27 September 2016

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## HEALTH AND SPORT COMMITTEE
**6th Meeting 2016, Session 5**

**CONVENER**

Neil Findlay (Lothian) (Lab)

**DEPUTY CONVENER**

*Clare Haughey (Rutherglen) (SNP)

**COMMITTEE MEMBERS**

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

*attended

**THE FOLLOWING ALSO PARTICIPATED:**

Alan Baird (Scottish Government)
Richard Foggo (Scottish Government)
Sarah Gledhill (Scottish Government)
Geoff Huggins (Scottish Government)
Gerry Lawrie (NHS Grampian)
Dr Miles Mack (Royal College of General Practitioners)
Dr Alan McDevitt (British Medical Association)
Lesley McLay (NHS Tayside)
Shona Robison (Cabinet Secretary for Health and Sport)
Shirley Rogers (Scottish Government)
Dr Gregor Smith (Scottish Government)

**CLERK TO THE COMMITTEE**

David Cullum

**LOCATION**

The James Clerk Maxwell Room (CR4)

# Scottish Parliament

## Health and Sport Committee

*Tuesday 27 September 2016*

*[The Convener opened the meeting at 10:00]*

## General Practitioner Recruitment

**The Deputy Convener (Clare Haughey):** Good morning and welcome to the sixth meeting of the Health and Sport Committee in 2016 in the Scottish Parliament's fifth session. I ask everyone in the room to switch off mobile phones as they can interfere with the sound system. We have apologies from our convener, Neil Findlay, so I will convene the meeting.

Agenda item 1 is an evidence session on general practitioner recruitment. We welcome to the committee Gerry Lawrie, deputy director of workforce, NHS Grampian; Lesley McLay, chief executive of NHS Tayside; Dr Miles Mack, chair of the Scottish council, Royal College of General Practitioners; and Dr Alan McDevitt, chair of the Scottish GP committee, British Medical Association.

We are not expecting any opening statements, so I move directly to questions. I will kick-off. We have heard a lot about there being a GP crisis. What is it about the current position that makes it a crisis?

**Dr Miles Mack (Royal College of General Practitioners):** My college has been campaigning on the issue since 2013, when we predicted increasing problems for general practice and that we would see GP numbers falling. Unfortunately, that fall seems to be happening, and it is causing us a real problem in delivering the GP service that we want to deliver. A third of practices in Lothian are unable to take new patients; increasing numbers of practices are being taken over by health boards, often with devastating results for patients; and there is increasing difficulty in recruiting GPs into the profession and retaining them for a long-term career. Those are important issues, and the situation seems to be completely at odds with the Scottish Government's ambitions for its 2020 vision and now for realistic medicine.

Physicians in the community deal with elderly people with increasingly complex problems and enable them to be looked after and cared for at home. We take great pride in our work and believe that having good, long-term relationships and really meaningful conversations with our patients is crucial in ensuring that the care that they get meets what matters to them. We provide continuity and are the first point of contact.

On that basis, it is crucial to look at the issue to ensure that we are taking the right steps, particularly by tackling the falling percentage of national health service funding that is going to general practice. The amount was set at 9.8 per cent in 2005-06, but it is down to 7.4 per cent in the latest figures that we have. That is despite the ambition of the previous Cabinet Secretary for Health and Wellbeing in asking health boards to spend more money on primary care, which was a commitment that was made to us in November 2014.

We continue to call for investment in general practice. We have clear evidence that we need it. I draw Helen Irvine's work to the committee's attention. Independently of the college, she has made it quite clear that investment in primary care will reduce inequalities, provide services for patients at home and reduce the requirement for accident and emergency and elective healthcare services.

**Dr Alan McDevitt (British Medical Association):** The BMA has been doing a GP practice survey every quarter for some time now. Our latest figures, which are from September, show a 28.6 per cent vacancy rate in general practices around Scotland—it was the same rate in June. We have seen a substantial change in the number of posts that are still vacant after six months—from 42 last year to 80 this year—so we are getting clear evidence of a major recruitment problem. In addition, practices cannot obtain locums to cover for GPs who are on holiday, sick leave or maternity leave. As Miles Mack has said, the result is that many practices are having to somewhat restrict the services that they provide. The problems that we are seeing now are very real and are beginning to affect patients. That is when it becomes a crisis—when patient care begins to be affected by the numbers of GPs that we have.

Although I often talk about the role of other professionals in helping general practice, it is also about making sure that general practice medicine is available to our patients and that in future patients can access a GP, as a doctor, when they need to. Today is as much about that as it is about the total redesign of primary care.

The key thing is that the crisis—the shortage of GPs—is now manifest and we are working very hard to change the fundamental nature of general practice to make it attractive for doctors both to stay in and to come into as a career. That is one of the fundamental reasons why the BMA is now renegotiating the contract with the Government: we want to try to resolve some of the underlying problems that have made general practice a less attractive career to stay in and to come into initially as a young member of the medical profession.

**Tom Arthur (Renfrewshire South) (SNP):** We are all very aware of the workforce pressures that the profession is under—pressures that relate to demography and the recruitment of new GPs. In particular, the number of unfilled vacancies seems to be the single most difficult problem that we face. Does the panel think that the use of the term "crisis" will contribute to a solution? I have found in conversation that, when the term is used again and again, a perception builds up that can be quite off-putting.

I was interested in what Dr McDevitt said—his language was more temperate to begin with, when he spoke about a "recruitment problem". I ask the panel to unpack some of the challenges, beyond the contract renegotiation and GP recruitment. Do you think that we can reframe the language that we use? I appreciate where you are coming from in defining the situation as a crisis, but I do not know if that contributes to solving it. I am keen to hear your thoughts.

**Dr McDevitt:** As we have been going round the country preparing for changing the contract, we have talked about changing the mood music. The first thing that we have to do is change the perception of general practice so that it is seen as an attractive career for young doctors. Unfortunately, the negative circumstances that we find ourselves in tend to make people say, "Well, I'd better not go and do that." It is vital to change the mood music.

We can look forward to a very positive future for GPs in Scotland if we manage to achieve all the things that we aim to achieve, particularly through contract realignment but also through changing the role of the GP. A GP should be an expert medical generalist in the community who is part of a multi-professional team and can focus on what we call "undifferentiated presentations"—in other words, the patients who think that they need to see a doctor and that they might be sick. A GP should also focus on complex care—dealing with people with more than one condition—and being a clinical leader who is responsible for improving the outcomes for patients, working together with them to bring about what patients want to happen in their lives in relation to their health. General practice is a fantastic career and we have to make sure that the role and circumstances of being a GP in Scotland are as positive as they can be. That is how to change the mood music.

The word "crisis" is not helpful. When does something become a crisis? Recruitment has been building as an issue and will remain an issue for some time to come, even when we are fixing things. I am not hugely fond of the word "crisis", but I am responding to the way that people are describing the situation. Call it what you like, but there is certainly a major problem and it will take some time to turn around. We will all have to work very hard together to fix it.

**Alex Cole-Hamilton (Edinburgh Western) (LD):** I believe that we are in an absolute crisis in terms of GP recruitment and am comfortable with that language, not least because no new medical centres have been built in my constituency for 45 years, despite the year-on-year proliferation of new housing and the fact that some surgeries have had to close their lists. I am very supportive of the call by the Royal College of General Practitioners for investment to be increased to up to 11 per cent of the health budget.

I want to explore the trainee issue. We know that not all the trainee vacancies that have been made available have been filled. Perhaps more alarmingly, the committee heard last week that not all those trainees are domiciled in Scotland and may not all go on to practise in Scotland. Can the panel bottom that out and give us an idea of the extent of that issue?

**Gerry Lawrie (NHS Grampian):** It is an interesting point: the trainees who are coming through now are not like the trainees who came through when I started in the national health service. Their expectations and career aspirations are very different. For example, in Grampian we have a predominantly female workforce, some of whom choose to work part time. We have some evidence that the male workforce is choosing to work part time as well.

Alan McDevitt referred to how GPs are marketed and sold. The image of GPs is not particularly positive and their portrayal in the media, particularly in television soaps, is negative. We do not portray becoming a GP as an attractive opportunity for people.

**Dr Mack:** I bring to the committee's attention the think GP campaign that the Royal College of General Practitioners has just started. We are very keen to ensure that general practice is portrayed in a positive way. We have four videos of GPs across the United Kingdom that show young doctors working at fantastic levels—the variety and challenge in what they do and the responsibility that they have.

It is clear to me that being a GP is, and should be, a fantastic job. We should be batting people off because so many want to get into general practice, as was the case when Alan McDevitt and I started our careers. There were far more applications for every post then, which meant that the best medical graduates got into general practice.

I take the point about using the word "crisis" and talking things down, and I regret that we have had to talk about general practice in negative terms. However, I believe that we have to tell the truth. If

the doctors who are training in general practice hear from my college that all is rosy, that there is enough money and that the future is sound, but see with their own eyes that doctors are working 10 or 12-hour days and feel that their ability to work and provide safe patient care is being compromised by a reduction in the workforce, that gives me, the college and the solutions that we have come up with no credibility.

I point out just how much positive work the college has been doing on the issue. We were ahead of the game with remote and rural recruitment back in 2012. We also explored the ideas that we have now brought forward as the GP career flow, in which we say that we cannot think only about the 100 new places but must also look downstream at what the GP career will look like in the future and how we can retain people.

We also have to look upstream. For example, I have just written a blog for the General Medical Council describing some of the issues around the bad-mouthing of general practice and psychiatry in medical schools. That just should not be happening, but it seems to be happening and is the sort of thing that we really need to challenge because it is not fair on the profession and is severely damaging it.

We need to ensure that we are training in the right way. I am delighted to say that yesterday I had sitting in with me in my surgery a fourth-year medical student who is spending 10 months of his fourth year in my practice learning general practice. I admitted to hospital two of the patients I saw as duty doctor yesterday, and the student has the opportunity to join the post-receiving ward round at Raigmore hospital tomorrow—to see what happens to those patients in the ward—and to follow them back into the community. If we want a joined-up approach to medicine, that is the way in which to train doctors and the sort of support that we need. That student is part of a pilot that is run from Dundee, which is exactly the sort of thing that we are talking about in our GP career flow.

I apologise if I seem negative, but one part of my role is to tell the truth and to ensure that there is a consistent approach across the board to providing the resources for the initiatives that we put forward in the blueprint document that we provided last June and in the manifesto.

**Lesley McLay (NHS Tayside):** As an NHS board chief executive, I want first to say that I fully acknowledge the challenges that exist in relation to general practice and recruitment. We have a number of workforce challenges, but the board and the health and social care system have a number of strategic plans that we implement locally.

NHS Tayside serves a population of about 400,000 and we have about 330 general practitioners. Our vacancy level is pretty constant at about 5 per cent. We are fully aware of the age profile issue, which is challenging the health and social care system across a number of specialties. Just now, about 15 per cent of our GP workforce are over 55, so that is clearly a challenge.

Locally, we are doing a number of things. For example, the board has a five-year primary care strategic framework, which our clinical leaders have put together. We are looking at the whole healthcare system. We have taken on board the opportunity to form clusters, which allow a clinical leadership model to form locally. In NHS Tayside, we have 13 clusters. A level of maturity is being established, and there is engagement across general practice. By looking at our data and information, we are supporting practices to tackle some of the challenges that they face.

We are doing a lot of work on the extended role of the multidisciplinary team. I am clear that GPs are the clinical leaders and that they sit at the heart of our vision for the delivery of primary care and community services over the next five years, but I highlight the importance of the wider multidisciplinary team and of the agency team, and the contribution that the staff in those teams can make in meeting the demands and the healthcare needs of the population that we serve.

10:15

**Colin Smyth (South Scotland) (Lab):** Dr Mack, you indicated earlier that the current crisis was predicted. What did not happen? Why were those predictions not heeded? What lessons can we learn to resolve the current crisis?

**Dr Mack:** Obtaining an increased percentage of funding for general practice lay at the core of our campaign strategy. That was what we brought to the previous cabinet secretary. We believe that we made that argument quite strongly. Giving the resources to general practice to provide the necessary staffing is the single most important thing that needs to be done. I am referring not just to general practitioner staffing, but to other members of staff. As Alan McDevitt suggests, we now need to think about having a wider multidisciplinary team to deliver care, because there will probably not be enough GPs in the immediate term. However, it is clear we must have the aspiration to increase GP numbers.

According to a Scottish Government press release, there has been a 40 per cent increase in consultant numbers. That has not been matched in general practice over the same period—there has been almost no increase in the number of GPs. Indeed, the workforce survey suggests that

we have lost 2 per cent of GPs in the past two years. It seems that the workforce planning has gone awry and that we are not investing in the workforce in the right place. At a time when we are talking about the 2020 vision and the provision of more community care, it seems wrong to increase consultant numbers by 40 per cent without bringing about a concurrent increase in the number of GPs and additional staff.

**Dr McDevitt:** When I came into general practice, we had only our reception staff. Now, we have slightly more staff. There are six GPs for a practice of 10,000 patients, and I have one whole-time equivalent practice nurse and half a healthcare assistant. Those are the only staff I have to deal with the acute demand as it comes into the practice.

We have a wider multidisciplinary team, but there has been a lack of investment in the structure that supports general practice. At the same time, the work that we do has become much more complex. As we have driven up quality, that has created increased demands, particularly on GP time. There has been a lack of investment in meeting the broader needs of patients as they present to general practice, which is where 90 per cent of patient contact occurs. In the main, the place where you and your family come into contact with medicine is general practice, but we have not invested substantially in supporting how that medicine delivers the best outcomes for patients. That strain is now telling in the enormous workload on GPs. We have no one else to share that with.

We need to find new members of the workforce. New GPs will be part of that, but we know that they will be slow to come on stream, so many other professions will need to join us in meeting the immediate patient need and demand on the front line. We need to have the right professional to deal with patient need, but we have not previously had the capacity to enable that to happen.

An example of how strange the situation became was that, if a patient who was at home needed a blood test, we were told that that could not be done by a district nurse because blood was part of the GP contract. It was a need that the patient had, but because of the way that people thought about how we worked under the contract, teams were prevented from working to meet patient needs appropriately. We need to get rid of all that and start working properly as professional teams, so that the right professional can meet the right patient need. There needs to be a much greater number of professionals available to share the workload that currently is dealt with mainly in general practice, because that is where the bulk of the work occurs.

That investment is an absolute requirement, and we call on the Parliament and the Government to invest in that way. I know how stretched the public purse is, but that is an absolute requirement. If you want to fix the issues and have general practice for your families and mine, investment in the new model of general practice is required now.

We are absolutely open to the kind of general practice in which the other professionals play their part and we have a greater offering to the public. Currently, general practice is the hub where most people come into contact with the NHS. We want to build up the hub so that a greater offering of professionals is immediately available to the public to meet their needs at the front line. We are up for making that the way forward, but the Parliament and the Government have to make that investment, even though times are hard.

**Richard Lyle (Uddingston and Bellshill) (SNP):** I have listened intently to the points that Dr McDevitt has made, and I agree that we have to look at that approach. To use a word that has not been used for a long time, let us reduce the demarcation and work together to solve the problem. It is not just about money. I agree that the money should be looked at, but it is about making a start. We need to start now to get more people in to become doctors. I am working on a particular case for a constituent who wants to be a doctor but who, unfortunately, is a few points short of the requirement to get into university. I have been to see the university and I hope that it is listening to me today. We have to train doctors in, I think, five or seven years—

**Dr McDevitt:** It is five years at university and then subsequently another five.

**Richard Lyle:** Yes; basically, we have to start now to train the doctors that we will need to resolve the problem. With the greatest respect, we have to look at each and every situation. Throughout the country, we have doctors who work in surgeries that they own, doctors who work in health centres, doctors who are paid by the NHS and doctors who basically manage their own practices—I think that they should be doctoring, if I can use that word, rather than managing. We have to look at the whole situation and resolve it. We have to look at money, but we also have to look at workforce and how we can encourage people. If anyone out there can help me to get the boy that I mentioned into university, I would be pleased, because he wants to be a doctor and his family is going through a terrible time because he cannot get in there because of a few points. Should universities look at that? Should we also look at demarcation within the gamut that you have spoken about?

**Dr McDevitt:** Governments are rightly looking to ensure that recruitment into medicine represents

the population. We know that people are more likely to serve their local populations, whether they be rural or deprived, so universities should absolutely ensure equity of access and Government should be involved in that. It will always be hard to get into medicine, because it is so competitive. Although the numbers of GPs have dropped, it is still the case that far more people want to become doctors than can become doctors. It will always be hard to get in, but we have to ensure that there is equity of access to universities across the social spectrum. A lot more work has to be done on that, because the current work is clearly not having a major impact.

**Richard Lyle:** Are you saying that there are more people out there who want to be doctors but who cannot be doctors?

**Dr Mack:** Yes.

**Dr McDevitt:** Yes—that has consistently been the case for a long time.

**Dr Mack:** The numbers applying to medical school are still consistently very high, although it is really sad that they are dropping off at later stages. Alan McDevitt is exactly right about where people come from. We understand that only 50 per cent of entrants into medical school are now domiciled in Scotland. Our international evidence, which is borne out by the remote and rural work that we have done, is that people tend to return to their place of domicile after university. That needs to be looked at.

I think that Richard Lyle is hinting at the idea of contextualised admissions, which I heartily applaud. There is very good evidence on reducing the grade requirements for people from particular backgrounds who find access very difficult; some of that evidence is from the Scottish Government's own work on removing barriers to education. That is not just about people from inner-city areas; it is a big issue for remote and rural areas. In some remote secondary schools, pupils do not have the opportunity of doing all four sciences and by default might not have the grades that are needed. They may also struggle to get experience of nursing homes, for example. We have had a real issue with remote and rural recruitment because of that. Contextualising admissions seems to be a clear way forward. It seems to pay dividends and probably means that we are more likely to get the doctors that we need.

I will say one thing about demarcation: there are real risks to it. We need to do whatever we can, but we also need to be clear about what the primary care team is. I am very proud of work that we did with the Royal College of Nursing, the Royal Pharmaceutical Society and the other primary care members to try to define what the primary care team is and what we can provide. We do not want artificial barriers, but we will need a network group of professionals who understand what their job is and what they can expect from others and who have really good communication links. That will involve defining what we do as doctors. It is important that doctors are clear about what our unique job is, and what nurses, advanced nurse practitioners and pharmacists can do.

**Lesley McLay:** I would like to build on that point. There are really good examples in workforce planning and development relating to the extended primary care team. The principle is about not the people who substitute, but looking at the workload and demand and allowing certain healthcare practitioners to work to the top end of their licence. In the nursing profession, particularly in primary care, we now have a number of advanced nurse practitioners and nurse consultants. Previously, a lot of the nurse consultants worked in quite specialist areas in secondary care, but nurse consultants now work in medicine for the elderly. In one of our deep-end practices in Dundee, for example, we have a nurse consultant with that background who works out in primary care.

There are really good examples of our allied health professionals and physiotherapists working with the clinical team and running particular clinics where they can be independent with an agreed scope of practice. That is being done collaboratively with the GPs.

At last week's meeting, the panel touched on the role of the pharmacist. Certainly in NHS Tayside, we have had pharmacists attached to GP practices for at least the past 10 or 15 years. That does not take away the challenges, but it helps address the demand and the workload, and allows pharmacists to undertake work that GPs do not need to do.

There is still a lot more work to be done, but really good examples are developing and emerging in the primary community care service, where there is real strength. I refer not just to the healthcare professionals. There are great examples of the third sector inputting and supporting: for example, by bringing to the practice patients who can be transported but have no access to transport they save the need for home visits.

Working on what that multidisciplinary team is is absolutely core, but we should recognise the opportunity that health and social care integration is bringing and the relationships with the third sector. It is about looking right across the whole health and social care system to support the increasing demand from the population.

**Richard Lyle:** How many training places do we have in Scotland for people to become doctors? I want to get that on the record. Do we know?

**Gerry Lawrie:** I think that this year's intake was 353.

**Dr Mack:** That was for GP training.

**Gerry Lawrie:** I am sorry; I beg your pardon.

**Richard Lyle:** Do we know how many students are going to university to become doctors? I am looking for another one to do so, but do we know how many there are?

**Dr McDevitt:** I certainly do not have those figures to hand. When I was at the University of Glasgow, the figure was 200 a year. That was one of the biggest medical schools.

I have exactly the same problem in helping the children of some of my patients to get into medical school. We have recognised that it is very difficult for some students to get access to experience with a GP because they do not know doctors, as Miles Mack said. We are trying to arrange a swapping arrangement in our area with another practice so that we can facilitate local children getting experience of general practice to try to help people from our communities to get into medicine. That is something that we share with you. I suspect that, at some point, we have all been involved in trying to help children to get into medicine. However, it is a difficult area, and it probably always will be.

**The Deputy Convener:** Could everyone please keep their answers slightly shorter?

10:30

**Gerry Lawrie:** In Grampian, we have been offering a scheme called doctors at work for school pupils who are on the academic route to becoming doctors. We have opened it up to the whole of Grampian and we take some students from outwith Grampian too, including those from Orkney and Shetland, who might not otherwise have access to such a scheme. It is running successfully. The pupils come for a week and spend time interacting with doctors and shadowing doctors, so everybody gets better access. One thing that is surfacing is about individuals' values and intentions. It is not just about academic ability, but about values, what you believe in and your commitment to becoming a doctor or a GP in future.

Another thing that I would like to mention on the back of the multidisciplinary team relates to physicians' associates, which I do not see mentioned. In Grampian, we run a course with the University of Aberdeen and are in our sixth cohort. We offer those individuals bursaries. They come from a different supply; they are generally science graduates and they do a post-graduate degree and then become part of our workforce. We are highly successful in placing them. In fact, we could place more, and those in primary care who have them are very enthusiastic about them. There needs to be more work and support around physicians' associates.

**Alison Johnstone (Lothian) (Green):** I will direct my first question to Miles Mack. When you spoke earlier, you talked about the devastating results for patients when practices were taken over by the NHS. I may have misunderstood that, and I will look back at the *Official Report* to check, but I would like to explore that mixed model further, if I may. Gerry Lawrie said that part-time working is more attractive to both men and women, which will obviously have an impact, but I want to understand whether the Government could be doing more to offer salaried positions, or whether you have any concerns about that model?

**Dr Mack:** There are a number of issues to do with that. Salaried posts do seem to be more attractive, particularly when doctors are concerned about the general medical services contract not being fit for purpose and about their workloads. I do not have clear evidence for this, but people seem to want to be salaried to health practices rather than health boards. We have concerns that some of the practices that have been taken over by health boards seem to cost an awful lot of money to run—sometimes twice as much—and we are not sure whether that is because of underestimates in the past or because self-employed doctors are an incredibly efficient way of running a practice.

The multidisciplinary team is important, but those of you who have a scrutiny role should make sure that you are aware of a review by the University of York centre for reviews and dissemination that was published in June 2015 and which pointed out that there is not clear evidence that such arrangements reduce the overall need for GPs:

> "Role substitution is being widely promoted, but the extent to which that will reduce GP workload is unclear."

The review also points out that other ways of working, including telephone triage and other things, are more about shifting work around than making life easier for GPs, so we have to be clear about what we want to achieve. The multidisciplinary way of working is not a cheap option. The members of that team cannot see patients at anything like the rate at which GPs can, and they need supervision. We need to build in the additional time that GPs will need to spend interacting with the other members of the team.

**Alison Johnstone:** You are saying that it is important that we look at the multidisciplinary team

model—Dr Elaine McNaughton gave evidence last week and said that it was not new to her, although it may be in some other areas—but while we are looking at it we must not lose sight of the fact that we must ensure that we have enough GPs, because that model is not a substitute for general practitioners.

The Scottish Government has told us that the number of GPs has increased by 7 per cent. I know that there are three members here who represent Lothian, but we have been told that we have 39 restricted lists in Lothian, and deep-end practices in particular seem to be suffering terribly. Are the extra 7 per cent of GPs that we are hearing about having any impact on health inequality?

**Dr Mack:** The extra GP posts are headcount rather than whole-time equivalent. We have clear evidence from the workforce survey that the Information Services Division performed that we have lost 2 per cent of GPs in two years. It may be that the headcount is increasing, but the whole-time equivalent—the actual number of GPs who are on the ground to deliver care—is not increasing. The trend is actually downwards.

**Alison Johnstone:** Dr McDevitt, in your letter to the committee, you raise concerns about a suggestion that more GPs might work between primary and acute care. Could you comment on that?

**Dr McDevitt:** That comes out of one of the many variations of hubs that are around, particularly in the Forth Valley area. We have worked to get an agreed position on that suggestion, but the idea that the future of general practice is a doctor who also works in secondary care and dips in and out of primary care is not one that we find attractive. We think that we need doctors who work in primary care as general practitioners—expert medical generalists in the community.

We have a very scarce workforce. The idea of sharing it in some intermediate role, as is indeed happening in Forth Valley, worries me. We cannot recruit people for the core general practice jobs but we are getting new jobs that take people away from general practice. Forth Valley was one of the first areas that had a major crisis in staffing general practices. There are things that we can learn from the pilot in Forth Valley, but we certainly do not see that approach as the future for general practice in Scotland. It is quite clear that having GPs in the community—expert medical generalists who are available to everyone in the community—is a fundamental part of the future for general practice in Scotland, as opposed to some other invention of what general practice could be.

**Maree Todd (Highlands and Islands) (SNP):** I am interested in developing that point further. Dr Miles Mack spoke very animatedly about the opportunity for his medical student to work in a rural general practice and to follow the patient into the hospital, go on the ward round and follow the patient back into the community.

As a clinician myself—although I am a pharmacist and not a medic—I found that what attracted me to my job was the quality of care that I was able to deliver and the clinical challenges. I thought that being able to move GPs into more complex care might make the job more attractive, so I would be interested to hear what—

**Dr McDevitt:** I am smiling slightly, because I reckon that my job is pretty complex. We deal with people from new babies to the elderly, pregnant patients to people with mental health problems—because you cannot separate mental health from the physical illnesses that affect people. GPs deal with all that every day.

In one surgery I will go through the whole spectrum of age and the whole spectrum of disease, and I will have to manage that all along. In addition, people have multimorbidity now. They do not have just one illness or one problem; they have heart disease and diabetes, have had a stroke, are depressed and have had a recent bereavement. One of the beauties of general practice is dealing with the whole person. That is the element of complexity that engages me. It is about real people with their real problems.

As well as that, we have an increasingly complex elderly population who we need to look after at home. If we continue to deal with older people with complex health problems by sending them to hospital, we will not be able to build the hospitals fast enough. We need to look after people close to home. There is no doubt about that; everyone is in agreement.

Taking on that complex medical workload is a real challenge, not least because right now there is not time to do it. As well as that, we have to continue to build our skills. As part of the GP contract in future we plan to build in regular time that is non-patient-facing for GPs to continue to upskill themselves in the role that they are taking on. It will be a much more complicated role, making sure that people with complex medical problems are cared for at home in the way that they wish to be. The advances in medical technology will allow that to happen much more often. That is a very complex part of our work.

Most GP training occurs in hospitals. We would like more of it to happen in general practice—that is an issue that we need to discuss—as we have plenty of experience of hospital medicine. What is needed is general practice medicine in the

community, so we have to make sure that that is what we are trained in, what we are experts in and what we train young doctors to do.

I have no qualms about saying that that is complicated enough to engage me for my whole career.

**Maree Todd:** So you do not see the potential for GPs to care for people in community hospitals?

**Dr McDevitt:** I am saying that they do that now. That is about buildings again; as someone else mentioned, we should not get too tied up on buildings. The sort of patients with complex problems who are in community hospitals are similar to those who are at home. Increasingly we will find that the complexity of your problem will not determine your location as much as your nature will. Basically, we are getting much better at dealing with things at home that in the past would have had to be done in a hospital or in a community care hospital.

There are many parts of the country where, for example, community hospitals are invaluable to the way that the geography works. Sometimes it is better to bring the patient to where the professionals are; at other times, in a bigger area such as a conurbation, we bring the professional to where the patient is. We need to be absolutely flexible about that.

The placement of care should be irrelevant; the issue is the complexity and quality of care that we can provide. The presumption should be for care in the patient's own home; we have to start with that and go from there. The patient should go elsewhere only when elsewhere will definitely improve the outcome.

**Dr Mack:** I raise the flag for rural medicine, where GPs are commonly looking after hospitals and doing amazing work. They obviously need extra skills for that and David Hogg, who is in the GP video, is an example of that; on the Isle of Arran, the GPs provide all the hospital care as well.

One of the big problems is that the recruitment crisis has put community hospitals at risk, as the committee members are aware. We have seen Lockhart hospital closing with the practice unable to cover that as well as the general medical services workload. The same thing happened to my practice. It was with deep regret that we had to stop providing care to the Ross Memorial hospital because we were unable to recruit the GPs needed to do the day-to-day work safely.

You are quite right; GPs have lots of skills and are invaluable to the NHS. At a time when we are short of GPs, we need to focus them where they are essential because no-one else is qualified to do the work that GPs do.

**The Deputy Convener:** For the record, there were 898 medical undergraduate places in August 2016. Do panel members want to comment on whether that is enough to provide the GPs and the medical staff of the future?

**Dr Mack:** It is probably more about retaining those into careers and making sure that their career flow is appropriate to where we want them to go. We can probably improve the conversion rate into general practice for Scotland if we undertake some of the ideas in our GP career flow proposals.

**Donald Cameron (Highlands and Islands) (Con):** Alison Johnstone asked most of the questions that I was going to ask. I have an observation that picks up the points that Maree Todd made about the potential for a GP to work in both general practice and acute services. I visited a community hospital in the Highlands and Islands that was operating what I think was called a rural fellowship. The anecdotal evidence was that a great attraction was that that GP could work for two days a week and then work at the local hospital for three days a week—or whatever the balance was. That mixed working was what made that job particularly attractive. Have you any observations on that?

**Dr McDevitt:** We have always done that. I was a clinical assistant in respiratory medicine; I have done medical politics; I have done all sorts of other jobs as well as being a GP. That is fantastic and is what we call a portfolio career—Dr Mack and I are what we call portfolio career GPs. That has always been part of general practice, but that is not what GMS and general practice are about. The core job is the two sessions that that GP does—that is what being a GP is. The rest is other things that doctors can do. There are lots of those, such as working for the Benefits Agency or the Government. There is always going to be the capacity for GPs to have other roles. What is often forgotten is the need to make the core role of the GP attractive; that is the reason why people come into general practice. If everyone who becomes a GP spends only half the time doing it, we are certainly going to need an awful lot more than we are already talking about.

We must make being a core GP a fundamentally attractive and interesting future career; just saying that it is okay because you can do other stuff is not the way to make it the future. It is interesting and good that being a GP allows flexibility in a career and allows other interests, but it is still being a GP that we need to make the biggest attraction to bring people into the profession.

**Lesley McLay:** I will pick up Maree Todd's point and build on it a little. I bring to the panel's attention some of the work that we are doing in

Tayside that we classify as enhanced community support. We are putting that in as core service provision that builds on the GP practice population and brings in the consultants for medicine for the elderly and psychiatry of old age—individuals whose jobs plans have them working in the secondary care sector and also in primary care.

10:45

We have good evidence from the initial pilots, which were targeting unscheduled care. We know the challenges for older people and unscheduled admissions. A rapid assessment is necessary from the team. That includes dedicated GP time, the psychiatry of old age consultant, the medicine for the elderly service, the pharmacist, the senior district nurse, social work services and the allied health professional going into the individual's home. It is an example of the GP working with other senior medical colleagues to undertake a rapid assessment. Often, they take the decision that the person needs to be admitted but they manage their admission and discharge.

We have had a lot of success. We have reduced the number of unscheduled care admissions and, when people have been admitted, the length of stay has been reduced. After piloting that approach, we are rolling it out fully. It is about helping and supporting the GPs and working with wider primary and secondary care colleagues to manage the patient journey.

**Ivan McKee (Glasgow Provan) (SNP):** Thanks for coming along. You said that you are keen to increase the percentage spend by 2 or 2.5 percentage points. Clearly, that means that somebody else will have a reduced spend. I throw that out to see what you want to say about it. To put that in context, the Scottish Government is talking about a shift to primary care, so I assume that, when you talk about GP spend, you are saying that, although there is money going to primary care, it goes not to GPs but to somewhere else in primary care. Is that correct? I am trying to get to the concept of preventive spend. We have heard before from GPs that, if we invest money in their services, we save money in accident and emergency. Can you put some flesh on that and say how we quantify it?

My second point concerns GP workload. We are talking about multidisciplinary teams and taking work away from GPs. I know that the witnesses have reservations about some parts of that, but the quality and outcomes framework has been done away with and pharmacists to whom I have spoken are happy that repeat prescriptions, for example, are coming away from GPs, so there are measures that are reducing GPs' workload. Has any analysis been done of how much of a day in the life of the GP is the stuff that they should not be doing and can go elsewhere? How much ground have we gained along that road?

**Dr Mack:** I am happy to speak about the percentage spend. I am sure that the Scottish Government will want to invest in the health service. It has been doing so consistently, but we need to ensure that we invest in the right place. For instance, we were disappointed with the most recent budget, in which the real-terms increase for territorial health boards was 3.8 per cent but the GMS rise was only 1.9 per cent. That seemed to be strange because of the issues that we had already observed. There will undoubtedly be investment in the health service in general; we just want to ensure that it is invested in the right place.

We have clear evidence from Deloitte surveys about the effectiveness of primary care. That is backed up by the work that Helene Irvine has done in Glasgow, which shows that the issue is not lack of resources but resourcing the wrong things and that, by investing a large amount in elective healthcare, we make inequalities worse. That backs up long-standing evidence from Barbara Starfield and others that shows that investment in primary care reduces inequalities and mortality. There is no clear evidence that that always happens when we invest in secondary care.

I am very grateful that the QOF has been replaced and proud that the royal college came up with some of the concepts that have replaced it, particularly the peer-led and values-driven approach. It will be a major way forward. It will give us the structure to provide leadership and consider not only the intrinsic quality of practice but the extrinsic factors of how we work within the NHS, which is a key part of the work that I have been doing over the past two years.

**Dr McDevitt:** Percentage spend is not always the most helpful way to discuss the matter. We certainly need an absolute investment in general practice in particular. By that, I do not necessarily mean the GMS spend, which is technically where it would normally sit, because we do not want to expand the number of staff whom we employ. We want to have other staff who assist us in doing the work that comes to the practice, but that does not necessarily have to come through my accounts, for example, because we want to reduce the burdens of being independent contractors to make it a more attractive future for GPs.

We need to find ways to ensure that we can agree between us the money to support general practice in its new role—if we get to that stage with the new contract, as we hope. Hopefully, we will come to an agreement with the Government about the investment to support general practice, because—as Miles Mack said—Helene Irvine has shown that a lot of the investment that has gone to

primary care has made no difference to general practice and the work that we do. That is due to a different focus on how that spend works and the outcomes that it is trying to achieve. We definitely want investment that improves the outcomes that we achieve through general practice. That will require a new look at how investment is counted as spending that goes towards supporting general practice as well as that which comes directly through the GMS spend.

**Ivan McKee:** I did not get the answers to my questions. First, if I spend a pound on GPs, how much do I save at A and E? Secondly, has there been any work done on how many hours GPs spend doing stuff that they do not need to be doing?

**Dr McDevitt:** On the second question, there has been a lot of different work done, but it is difficult to pick it apart. Patients do not usually come to their GP with just one issue—like in supermarkets, they come with more than five items—so it is difficult to say what GPs should not do. GPs are extremely efficient and they are almost certainly the most efficient single group of people to deal with all those issues. Cost effectiveness is a good argument for dealing with those issues with more GPs because they are remarkably cost effective.

**The Deputy Convener:** I am sorry to interrupt you there, but you touched on a point that Dr McNaughton brought up at last week's meeting. She said that the cheapest and most cost-effective way was to get GPs to do absolutely everything—her expression was that they could

"do things all in a oner."—[*Official Report*, *Health and Sport Committee*, 20 September 2016; c 27.]

However, that would not give the patient the best service.

**Dr McDevitt:** I disagree. I think that it gives the patient a very good service. Anyway, we cannot do that as there are not enough doctors, so we are changing that approach. New aspects of quality of service are brought in by other professionals who bring skills in addition to those of the GP.

In terms of cost effectiveness and improving outcomes, GPs are remarkable cost effective at what they do. Based on a number of different people's opinions, it is probably true that about 25 per cent of the work that I do every day could be done by somebody else—and could possibly be done better. That is the scale that we are talking about and that might free up 30 per cent of my time to deal with complex care—the new agenda for care for patients—and to make the job more humane.

Many of our colleagues say that the workload is inhumane and they are choosing to get out of it in one way or another by either going part time or leaving the profession; 259 GPs under 50 left the profession in the past five years and 200 of those were under 40 when they decided to get out. We have to change the GP's role to make it a good job that is manageable in humane terms despite dealing with the new complex workload. It is true that GPs are happier working in a proper multiprofessional team and I am fortunate that I still have one, as it is a great team to work in. The demarcation issues that Richard Lyle hinted at disappear when a team works well and everyone knows what each other's role is. We know how we are best placed to deal with things and we contribute equally to that effect. Once you get a good team working, the demarcation issues disappear.

**Dr Mack:** I have some specific figures for potential savings that Deloitte came up with for us in 2014. In reduced A and E attendances and social admissions, the saving was between £26 million and £37 million; in reduced ambulatory care sensitive conditions admissions, it was between £12 million and £27 million, depending on low and high ratios; in decreased alcohol consumption, it was between £4.7 million and £7 million; and in smoking reduction, it was between £5.6 million and £9 million. The estimated totals give a range between £48.9 million and £81 million. Those figures, produced by Deloitte, are on our website.

**Ivan McKee:** Those figures are based on an investment of how much?

**Dr Mack:** I would presume that the basis for that was noted in our campaign call, but I need to check that.

**Ivan McKee:** If you could send that to the clerks, that would be super.

**Miles Briggs (Lothian) (Con):** I would like to go back to Richard Lyle's point about recruitment, especially with regard to how universities are helping to meet the demand. How do you feel about how the university sector is planning the workforce? I was told yesterday that the University of Aberdeen has 160 places for medical students and that they have reduced the number for Scotland-domiciled students by 12 places for the current academic year. Can we do more and say to the universities in Scotland that they have to take a larger percentage of Scottish students to study medicine? Given that we fund Scottish universities and that international students pay £30,000 a year to take that course, is the Scottish Government failing to do that?

**Gerry Lawrie:** When I started my career in the NHS and I was involved in the induction of the new junior doctors who were leaving medical school, I asked how many of them had trained locally and about 95 per cent put their hands up.

Twenty years down the line, I am lucky if the figure is 50 per cent among the new graduates who start with us. I am disappointed that the University of Aberdeen has reduced the number of places, because we are struggling to recruit not just in primary care but in other areas. I would strongly emphasise the need to get local students into the Grampian area—when I say "local", I mean from the north of Scotland, including from Shetland, Orkney and Highland, because there is movement between those areas.

**Miles Briggs:** To what extent will Government incentives such as the £20,000 that is being provided and the 100 additional training posts make any difference?

**Gerry Lawrie:** That £20,000 is allocated only to certain training schemes, and we have only three in the north. We have recruited relatively well this year for our GP training scheme, but that does not mean that it is always going to be that way.

**Dr McDevitt:** I am not an expert on this, but it seems to me that universities are almost just educational businesses and it is for the Government to influence how they operate. As you have hinted, there are other routes through which they can get funding. It is also true—Miles Mack has done a lot of work on this—that the feeling in universities and medical schools is not positive towards general practice, and it is fundamental that we change that.

On the flow of new GPs coming through, there are lots of places where our potential GPs drop off, including getting into university and their choice of specialist training once they have come through the foundation years. We also need over 50 per cent of junior doctors to choose to become GPs, and they are not doing that. Even when they do make that choice, they are often lost to our workforce at the end of their training. There are lots of places where we lose potential GPs, and we need to fix that.

We have asked the Government to address the matter, and the minister announced at our conference this year that she will produce a workforce plan, part of which will focus on how we can produce the number of GPs that we need for the future. That will be difficult because we are changing the role, the demands of the population are changing and all the other workforces come into play. Trying to predict how many GPs we need is therefore a bit of a black art. We certainly need more now, and we need to produce more than our system is currently producing. However, it is a work in progress to say how many GPs we need to produce, and the universities are a fundamental part of that.

**Dr Mack:** There is good evidence that training doctors in general practice provides good value. Not only does it provide more GPs, there is evidence that doctors who end up in hospital posts have better communication skills, are better able to deal with risk and make better use of resources because of the training that they have had in general practice.

**Lesley McLay:** I fully recognise all the factors that determine where people will end up after their training. Notwithstanding that, however, I still think that there is a role for the healthcare system in engaging as early as possible with undergraduates across all the disciplines to entice and encourage them. We must work hard at that to retain them in our system.

**The Deputy Convener:** I thank the panel for coming along this morning to speak to the committee. It has been enlightening for all of us. I suspend the meeting briefly for a change of witnesses.

10:58

*Meeting suspended.*

11:02

*On resuming—*

## General Practitioners and GP Hubs

**The Deputy Convener:** We now welcome to the meeting Shona Robison, the Cabinet Secretary for Health and Sport, and from the Scottish Government we welcome Richard Foggo, deputy director in primary care, Gregor Smith, deputy chief medical officer, and Shirley Rogers, director for health workforce. I invite the cabinet secretary to make an opening statement.

**The Cabinet Secretary for Health and Sport (Shona Robison):** Thank you very much, convener. I have provided the committee with a written update on the significant progress that we have already made and our next steps in supporting general practice and transforming primary care.

It is fair to say—I have said it before—that general practice is at the very heart of our NHS. With over 90 per cent of healthcare being delivered in primary care and more than 24 million consultations in general practice every year, we must ensure that Scotland's GPs get the support that they need in order to flourish.

However, we know that, as you have heard, general practice is under significant pressure. The scale and nature of demand are changing, with an ageing population, increasing complexity and the continued impact of health inequalities. To meet such challenges, we cannot continue to look back; instead, we have to focus on a vision for the future.

Last December, therefore, I set out in Parliament my vision for a community health service that is at the heart of Scotland's NHS. In that vision, a wider range of services would be provided by a wider group of highly skilled professionals, who would work as integrated teams and deliver care in and out of hours, tailored to local needs. Scotland's GPs would provide leadership within those teams, and there would be an enhanced leadership role for Scotland's nurses, pharmacists, paramedics and other allied health professionals.

In my written update, I have set out the outcomes and actions that will deliver that vision. We have increased investment in our primary care fund to £85 million over three years. To ensure that that investment makes a difference, we are testing new models of care in every health board area, with a focus on improving primary care mental health and out-of-hours services. More than 80 tests of the new model are already under way.

We have also committed to increasing the share of NHS funding for primary care year on year throughout this session of Parliament. As investment grows, we will use it to support local areas in rolling out the most successful tests. That is a measured and evidenced approach to change. After all, if the future of primary care is multidisciplinary, the bulk of our investment should be in the primary care workforce.

Of course, we have already taken a number of actions. We have increased GP training places from 300 to 400 per year, we have invested £2 million in GP recruitment and retention, including for a rural medicine collaborative and the deep-end practices, and we have committed more than £16 million to recruiting 140 whole-time-equivalent pharmacists in general practices. Moreover, in the programme for government, we have committed to increasing the numbers of GPs and nurses who work in our communities. We are recruiting 250 community link workers to work with GPs in the most deprived communities, and we will over the next five years train an additional 1,000 paramedics to work in community settings.

I think that that is the basis of long-term change, but we know that general practice faces pressures in the short term. That is why, in March, I committed an additional £20 million for immediate support to GPs and their practice staff. That money provided an uplift in GP pay and expenses, supported the introduction of GP clusters, introduced occupational health cover for GPs and ensured fair parental-leave arrangements for GPs. All those issues and priorities were raised by the profession itself.

The longer-term changes that we seek cannot be delivered through the GP contract alone, as they require changes to the wider workforce and infrastructure, but we are working effectively with the British Medical Association to deliver a new GP contract from 2017. That collaboration has already allowed us to abolish the bureaucratic quality and outcomes framework and to introduce GP clusters.

I know that everyone around the table is committed to the future of general practice in Scotland. We recognise the challenges, but I am ambitious for the future of general practice and primary care, so I welcome this opportunity to discuss the plans with the committee.

**The Deputy Convener:** Thank you, cabinet secretary. We now move to questions.

**Alex Cole-Hamilton:** I thank you, convener, and I thank the cabinet secretary and the rest of the panel for joining us this morning.

In the previous evidence session, we had a protracted discussion on how the situation with workforce planning, particularly in the GP sector, might be characterised. I am very keen to hear from each of the panellists individually on whether they would characterise our current situation as a crisis. After all, although more training places are being made available, they are not being filled, and when they are filled, they are not always being filled by Scotland-domiciled people. Despite the fact that there might have been an uplift in headcount in the GP profession, we are actually seeing a drop-off in full-time-equivalent posts, to the extent that we might by the end of the decade have as many as 900 fewer GPs than will be required. Is that a crisis?

**Shona Robison:** It is, without a doubt, a challenging situation—I have never shied away from saying so—which is why I have, since I became cabinet secretary, spent a lot of my time looking at the future of primary care and its importance in helping us to develop a sustainable NHS. In fact, I have probably spent more time on that than on any other issue. If I had not recognised that there was a challenge, I would not be doing that.

We have also engaged very effectively with stakeholders in discussing solutions to the challenges, but there is no single quick fix. We have already accepted that we need more GPs; however, this is about not just the number of GPs, but what those GPs do. That is why the new GP contract is so important; it seeks to support new models of working, including multidisciplinary models that utilise the skills and abilities of other staff to ensure that we can get a sustainable model of primary care.

As I have said, I have never shied away from making clear the scale of the challenge, but the more important issue is what we will do about it. On Scotland-domiciled students, which Alex Cole-Hamilton mentioned, we have taken a number of actions. We are from this year onwards increasing by 50 the number of undergraduate medical places, and we have been very clear with universities that we want the widening access agenda to feature very strongly in respect of those additional places. Moreover, we are well along the way with our plans for a new graduate medical school, which will have a very clear focus on primary care and rurality.

We are also looking at ways of linking the payment of graduate fees with a commitment to working within our NHS—the most important thing is to keep doctors who train here working in our NHS. There are many who are not Scotland-domiciled who have trained here and have worked here for long periods of time—we want more of them to choose general practice over other specialties. That is one of the challenges; again, I say that we have been working with the medical schools on how we can make general practice more attractive. We have also increased the number of training places and are providing some interesting and different opportunities through, for example, the GP fellowship scheme—which is attracting quite a lot of interest—and bursaries.

We have looked at a wide range of mechanisms to get more young people to go into medicine, choose general practice and stay working here in Scotland. The graduate programme will encourage a wider variety of people of all ages and from all backgrounds to go into medicine, which will be good for the medical workforce in Scotland.

**Alex Cole-Hamilton:** I do not doubt for a minute the sincerity with which you are approaching the problem, but would you characterise it as a crisis?

**Shona Robison:** No—I would characterise it as being very challenging. We could sit and discuss terminology all morning, but would that really get us very far with solving the problem? I very much doubt it. I am focused on coming up with a range of solutions that get us to a point at which people want to go into and stay in general practice here in Scotland. The issue is not easy to resolve, because it is partly about the perception of general practice, partly about how our medical schools work and, perhaps, partly about the perception in medical schools of where general practice sits with regard to other specialties. The issues are quite deep rooted and complex, and there is no solution to them. That is why in the written material that has been provided to the committee, and in my remarks to the committee this morning, a number of solutions have been touched on from recruitment at undergraduate level through to training.

However, the most important thing in all that is the vision for primary care. If we can create a vision for primary care that doctors want to be part of, many more will choose general practice, alongside other professionals who will want to work in primary care instead of other parts of the NHS. I hope that that is what we will focus on this morning.

**Richard Lyle:** From listening to you, I think that you are starting to think outside the box. I believe that we need more financial help for people to become doctors. Should we have incentives for people to stay in or to get into general practice? Should we have more training places? After all, something is being made of the number who are falling off. I am trying to get a constituent into a training place, but because he is a couple of points short the university is reviewing the matter. I hope that he gets the place.

As I have already said this morning, there might be an issue of—to use an old word—demarcation. If I walk into the practice with, say, a cough or a sore finger, I should just go and see a nurse, not a doctor. Is there more that we can do to reduce the amount of time that people are seeing individual doctors when they could be seeing nurses or someone else in the practice? Can we get doctors just to work with patients in a sort of health-centre setting instead of their trying to be managers, employers and so on in their own practices? Do we need to start thinking outside the box to resolve this challenge?

11:15

**Shona Robison:** Yes, we need to do that. The role of the GP is pivotal. That has been, and will continue to be, the case, but the new approach that we are taking utilises the range of skills that sit within primary care and co-ordinates it through a genuinely multidisciplinary team. I heard Alan McDevitt say at one point that 25 per cent of what GPs do could be done by someone else. That is not about providing a lesser service, but about acknowledging, for example, that pharmacists are trained to do medicines reconciliation. It is about ensuring that the patient gets the best service using the skills of the wider team, whether they are they are the skills of the physiotherapist or mental health worker. There is nothing earth shattering about that—it is a bit of a no-brainer, really. However, we need to make it happen and ensure that the contract and the model of working in primary care support that approach. That is what we aim to do.

Richard Lyle mentioned the incentives that we have put in place. The additional training places are important, but it is a challenge to fill them, as I have accepted. However, the number of applications is showing some positive signs and we are in a better place than we were last year in that regard. There is still more work to be done. It has been important to make some of those training places more attractive. We have adopted some innovative ways of doing that, with some success.

Everything that Richard Lyle mentioned is important—there is no magic bullet and we need to ensure that all those things are in place. We will not change the perception of general practice or primary care overnight; it will take time. We need to ensure that testing of new models provides evidence that will enable their roll-out. Some really interesting data are beginning to emerge from the test sites that will stand us in good stead. There is no single answer.

**Richard Lyle:** You may want to come back to me on this. I am sorry that I keep pressing the matter, but do your officials know how many people are refused places to train as doctors? I am particularly interested in one case, but I am sure that there are many more, and I invite anyone who is in a similar position to contact me. I want to know how many people are being refused places.

**Shirley Rogers (Scottish Government):** I will pick up on a couple of themes that also relate to Mr Cole-Hamilton's question.

The context in which we are operating is that there is an international requirement for additional medical staff. The issue is not unique to the United Kingdom or Scotland; it is an issue in most of the developed world as the population ages and expectations of health increase. Therefore, our ability to recruit, train and retain our people has never been more important than it is at the moment. We also have the advantage of having in Scotland five well-regarded medical schools that attract candidates from all over the world. I think that we all want Scotland's medical schools to be highly regarded and highly reputed. We know that they attract a high number of international students.

Because of the selection criteria, Scottish universities are able to be quite discerning. I routinely have conversations with the Scottish Board for Academic Medicine, which is the group that represents medical schools in Scotland in this context. We continue to work on the selection criteria. We get many more applications to Scottish medical schools than are offered, both from Scotland-domiciled and international students. We all accept that we want the very best of the best to be medics here—we want the people of Scotland to have the best medics they can get.

We have been working with the universities over the past couple of years to identify issues related to access. Richard Lyle is right that there are people who are not quite making it into those spaces. We have worked closely with the universities on their recruitment arrangements, but it would be inappropriate for us to determine them—candidates have to meet all the necessary academic tests. We have, however, made it clear to the universities that we want them to be in partnership with us in order to provide the NHS in Scotland with the supply of medics. We are very keen to work with them on access; the Cabinet Secretary for Health and Sport has already mentioned some of the approaches that we are taking.

There is now evidence that Scotland-domiciled students are more likely to go on to practice medicine in Scotland. Analysis from across the UK shows that students are more likely to stay to practice in the place where they went to university. It is in our interests to make sure that Scotland is as attractive as it can be. While we are doing a

number of things that the cabinet secretary has outlined to try to make that attractiveness more important, we are also making sure that the attractiveness of the general practitioner role is critical.

Dr McDevitt made an important point earlier about the 25 per cent to 30 per cent of work that is being done by GPs that is not appropriate for GPs. That is wasteful and does not necessarily give the patient the best outcome, but it is also important because it makes the GP role less attractive. Richard Foggo is working—through the primary care design team, alongside Dr McDevitt, Dr Mack and various other stakeholders—to make that role so attractive that highly mobile, well-educated and well-reputed doctors stay in Scotland. We seem to be making some progress on that. Such things as the clinical fellow scheme have been very important in attracting and retaining people to stay in Scotland. If there are people who Richard Lyle believes are on the cusp and are inappropriately deselected, that is something that I would be very happy to provide further advice on.

**Alison Johnstone:** What I will probably take away from this morning's session is that we will not have a truly multidisciplinary approach if we do not have enough GPs in place. That is absolutely an area on which we have to focus. The Scottish Government says that there has been a 7 per cent increase in GPs but, as I mentioned earlier, in Lothian there are 39 restricted lists. I would like to understand whether the 7 per cent relates to head count or whole-time equivalents, because it does not quite add up. It seems slightly contradictory.

We heard evidence earlier about a contradiction in approach; if we truly want to shift the balance of care from the acute sector to the community, what impact are we having on health inequality? Although nobody would suggest for a moment that we do not invest in elective procedures, for example, there has been a notable increase in the number of consultants at a time when we are truly struggling to recruit enough GPs.

Is the funding matching the intent? Are the funding and the focus matching the rhetoric?

**Shona Robison:** The 7 per cent relates to head count. I have said that we need more GPs. However, we also need more nurses, pharmacists and other health professionals in the multidisciplinary setting. The workforce plan that will go along with the new contract and new models for primary care is very important in that context, to make sure that we get that as accurate as we can. A lot of work is going on to make sure that, alongside the new models and the contract underpinning them, we have the investment plans and the workforce plans that will allow us to get the right number of GPs—as well as the right number of nurses, physios and other health professionals—to populate the new models and make the multidisciplinary model work effectively.

We have committed to providing primary care with an increasing share of funding. That will be subject to our meeting the needs of the new model of primary care. We are in the process of negotiating the new contract. Part of the outcome of those negotiations will be the provision of an important funding element to underpin the new model that will be delivered. All those things are hugely important.

You mentioned the need to tackle health inequalities. I have said on a number of occasions, and I repeat, that the way in which we fund practices through the Scottish allocation formula needs to better reflect the health inequalities dimension of practices' populations. We have gone some way down that road with the formula and the funding of the deep-end practices, but I strongly believe that health inequalities need to be better reflected in the funding. That is one element of the series of negotiations that we are having on the new contract. It would be inappropriate for me to go into too much detail on that, because those discussions are on-going. All that I would say is that the process is going well, and there is a huge amount of common ground and agreement.

We also need to look at how we better link the primary care workforce with other elements of support that people who live in communities of deprivation require. In the recent debate, the point was made that we need to look at income maximisation, employability and all the issues surrounding individuals and families that impact on their health. Through a new model of primary care, we can link more effectively into the world of integration, welfare and benefits support and employability advice. There are some good examples of that. For example, the Wester Hailes healthy living centre, which is funded through the 2C mechanism, provides a one-door approach to all those services. Even under the existing contract, there have been mechanisms that have led to such innovative projects, but there is scope to do more of that and to ensure that, when someone comes through the door—regardless of their needs—they can be met by a wider team of people who can start to have an impact on the health inequalities that their family and their community face.

**Donald Cameron:** Thank you for coming to give evidence, and for your letter of 22 September.

There is obviously a difference between primary care funding in general and funding for general practice. Does the Government have any plans to increase the share of NHS expenditure that general practice receives?

**Shona Robison:** We want to increase the share of spend on general practice and primary care within the wider health budget. We have made a commitment to increase the share of spend on that over the course of the parliamentary session, but we cannot look at the funding of general practice in isolation from the funding of the wider primary care team.

If we accept—as everyone around the table seems to have done—that multidisciplinary working is the answer when it comes to how we should deliver primary care services in the future, we must invest in the wider primary care team but, within that, we will need more GPs. As I have said, we are clear about that in the programme for government. Therefore, we will need to increase the number of GPs and to spend more on ensuring that we have a greater number of GPs.

11:30

However, it would be a mistake to do that in isolation from the primary care team because, if we did that, we would not get primary care into a sustainable position or tackle the fact that 25 per cent of a GP's workload could be effectively done by someone else. If we were not to invest in that wider primary care team, we would not maximise the efficiency of our primary care model and service.

Yes, we will need more GPs and, as a result, we will need to fund that additional workforce. However, that has to sit within a context of an increasing share of funding for primary care more generally; otherwise we will not get the sustainable model that we need.

**Ivan McKee:** I want to touch on two areas. First, on preventive spending, I want to ask you the same question that I asked the witnesses in the previous evidence session. Do you have any analysis or data on how much spending on GPs or wider primary care saves through reduced admissions to A and E and the acute sector?

Secondly, I have looked at the great big list of pilots. That is great, as it means that you are trying a lot of different stuff to—I assume—see what works. Can you elaborate on how you will evaluate the success of those pilots? What are you looking for in what you are measuring? We have previously heard that, for a lot of the pilots, the funding is for only a limited period. How will all that be rolled out? I assume that what you will do is figure out which ones work and then have a mechanism for rolling them out across the country.

**Shona Robison:** I will bring Richard Foggo in in a minute to give you some more detail, but I should point out that we did not magic up these test sites; the work was done in partnership with localities and with local boards and partners. They have essentially taken the direction of travel in which we are all heading and have localised that into a model that they want to test out and which meets their local needs. There is nothing wrong with that; after all, areas are different. There is rurality; there is deprivation, and although the multidisciplinary model is the common thread, its specific application will differ slightly from area to area. As I have said, there is nothing wrong with that.

The evaluation of the models will be an on-going process—we are not going to wait until five years down the line and say, "Well, we think that worked"—and many of those test sites will then be embedded as the way in which primary care will be delivered in that locality. I believe—Richard Foggo will say more about this—that we will be getting significant change and visibility of change by as early as next year and, as part of a two to three-year process, we will embed those new models and roll out the practice and learning from that elsewhere alongside our funding, investment and workforce plans. That will allow us to scale up the change and ensure that what we see in primary care over the next few years is dramatically transformed from where we are at the moment.

Do you want to say a little bit more about the test sites, Richard?

**Richard Foggo (Scottish Government):** I would just emphasise the cabinet secretary's comments by making it clear that at the heart of this is a deeply collaborative model, the wisdom for which does not lie in St Andrew's house. The first thing to say, therefore, is that we are working with every health board area and integration joint board to determine and support the work that they want to do to deliver those outcomes. In a sense, our evaluation supports their own evaluation of their local practice.

We are working through the Scottish school of primary care to put on top of all that a national evaluation that will allow us to identify some key themes and then to determine what is appropriate locally, regionally and nationally. Again, I do not think that we are talking about a classic top-down roll-out of one solution. Having considered the evidence that has been given today and which was given last week, I think that it is clear that there is a multiplicity of models out there to suit rural and urban environments and different demographics.

Our job is, I think, to determine the national components of that support, which in particular might include workforce and infrastructure supply. Some of the IT, digital and data issues on which I know you have taken evidence lend themselves to a once-for-Scotland approach, not to being done 14 or 30 times. Again, though, this is determined

by local change. That means that our piloting work is determined by what is already happening locally, and we look to support and get behind that. That gives a sense of ownership and direction rather than a sense of St Andrew's house setting down a strategy that people have to comply with.

There is a risk there. There are many tests—more than 80 and possibly up to 100—but that is a distinct advantage. There is a key underlying theme, which is multidisciplinary working in the context of integration. We will begin to form themes, to gather the knowledge and to determine what we can do nationally to support the local efforts, but the local efforts drive the change.

**Ivan McKee:** What about the preventive spend?

**Shona Robison:** As some of the information that I gave Alison Johnstone indicated, the new model of multidisciplinary working is about ensuring that we provide a joined-up approach through primary care that links with other parts of the public sector, whether that is welfare advice, debt counselling, employability advice or educational opportunities. That is important in what we collectively call preventive spend. It tries to ensure that we use our primary care infrastructure and workforce to prevent ill health and intervene early.

We have not been as effective at doing that as we could. The new model can help us to do that because, by its nature, it opens up the opportunity for multidisciplinary working, such as the Wester Hailes healthy living centre. I encourage you to go along to that centre and have a look at it if you have not had the opportunity. It has preventive work at its core. It is about intervening early and enhancing life chances. Everybody from the GP through the welfare rights worker to the voluntary group has a focus on trying to build resilience in individuals, families and communities as well as providing a health service.

There is a lot that we can take from that service. It will not necessarily provide the model for every community, because some will be more sparsely populated than Wester Hailes is, but the concept of multidisciplinary working is the same. It is about joining the dots, bringing in all the skills and expertise and involving the voluntary sector more effectively to provide support to individuals, families and communities that could be better provided.

**Ivan McKee:** I am looking for data. If you spend £1 upstream, how much do you save downstream?

**Shona Robison:** That data is available. We can provide it to you.

**Richard Foggo:** I would be happy to write to you with the data, Mr McKee.

**Ivan McKee:** Thank you very much.

**The Deputy Convener:** I am mindful of the time, so I ask everybody to keep questions and answers brief and to the point, if possible.

**Colin Smyth:** All the evidence that we are getting from GPs on GP hubs points to a unanimous view that the multidisciplinary team approach is the way forward. However, last week, the convener commented that we have more pilots than there are at Heathrow. Audit Scotland has indicated that the shift to the new model of care is not happening quickly enough. It says:

> "The Scottish Government needs to provide strong leadership by providing a clear framework to guide local development and consolidating evidence of what works."

Are there any plans to provide that framework to help local development? If so, when will it be provided and when will we move from all the pilots to agreement that the new approach is the way forward and to a sustainable model with sustainable funding?

**Shona Robison:** It is not a case of having pilots, getting round to evaluating them and perhaps carrying on with some. A test site is different. It is about changing the way things work and, if that is successful—which we believe that it will be because it is based on evidence—ensuring that the change happens throughout the area. We have given some flexibility, although the commonality of all the test sites is multidisciplinary working. There is none that sits outside the thrust of the way in which we have agreed that primary care should be provided in the future.

The basis of the bids was a set of criteria that was common to all. The application of the criteria took into account rurality, deprivation, the assets of the locality and what those in the locality believed would be the most effective application of the model. The national evaluation and the on-going support are there—Richard Foggo mentioned that earlier and I am sure that he can provide more detail. We envisage rolling out the practice with some changes, as there will inevitably be some changes in the light of the experience of the test sites. Nationally, we will underpin the new model with infrastructure, investment and workforce plans to ensure that we have the people to populate it on a scaled-up basis. That work is on-going while we build those supporting plans at the test sites.

**Richard Foggo:** To get the balance right, I would just add that, where leadership has been needed, it has been provided. The removal of the QOF and the introduction of GP clusters was done based on evidence but not based on tests or pilots, and we are watching that develop. Where

there are opportunities and where there is collaboration and consensus on steps that we might take, those steps have been taken.

The introduction of GP clusters is an enormously significant move towards a multidisciplinary future. They are at a very early stage, but that was a significant step. There is a balance between local leadership and determining what is suitable for local purposes and, where necessary, taking national steps to address immediate concerns through negotiation and broader collaboration. In that context, the removal of the QOF and the introduction of GP clusters is a very significant sign of leadership.

**Shona Robison:** Would you add a little bit about evaluation and roll-out?

**Richard Foggo:** To build on the previous point, we are working with the Scottish school of primary care to provide national support, but each project that we work with has its own evaluation. Having visited a number of those sites, we noted that local areas see evaluation as part of their own development plan—they do not do it because they are contracted by us; they are developing it for local purposes.

The changes are not waiting for national approval. Many of the test sites on the list are happening and we are supporting them, but they would be happening anyway. Those changes are being made in order to meet the changing demand of the changing local demographics. We will capture the key national themes and we will provide the national leadership that is required on workforce, infrastructure and funding, but the changes that are needed in Shetland, Stranraer, Dumbarton and Dunbar will be quite different. Those configurations will be for local partners to determine.

**Miles Briggs:** When we had an evidence session on GP hubs a few weeks ago, those on the panel who were involved in establishing them in Scotland could not give us a definition of what a GP hub should be or tell us which allied health professionals should be associated with them. What definition would the cabinet secretary give for a hub?

My second question is about link workers. What training and what qualifications will a link worker have and what role do you envisage them having in a hub setting?

**Shona Robison:** The hub is about multidisciplinary working and the application of the hub is different in different localities. Due to the geography of a rural or very remote area, the members of a multidisciplinary team do not all necessarily work out of the same premises, although they can nonetheless work as a team. It looks and feels a bit different but the outcome should be the same. All those dots are joined up and the team works as one, hopefully bringing in wider skills such as welfare rights, debt counselling or any of the skills of social care staff—all the things that we have talked about. The hub and the multidisciplinary team model applies out of hours, and it will apply for urgent care hubs and community health hubs, which you have heard a lot about. The common theme is multidisciplinary working.

**Miles Briggs:** Which health professional should definitely be attached to a hub. For example, should each hub have a physiotherapist?

11:45

**Shona Robison:** There will be a core of healthcare professionals. The skills that are available in the healthcare team in a remote community will be slightly different from those that are available in the healthcare team in an urban setting because of the nature of the population, which is smaller and sparser. Although the range of skills available, whether in the healthcare team or in the voluntary sector, will be slightly different, the principle is the same. Outwith that core set of healthcare professionals, there will be members of the voluntary sector and people with other skills who can be pulled in. As I have said, the situation will vary from community to community, but the core members of the multidisciplinary team will be the pharmacist, the physio, the nurse and the GP. The GP will be at the heart of the team, pulling together all that multidisciplinary working and providing the clinical leadership that will be so critical for that to work.

As far as link workers are concerned, we already have the link worker model, which is working pretty effectively. We have said that we want to increase the number of link workers—we have made a commitment to provide 250. I know that you have expressed some concern about whether they would have the necessary skills to address some of our mental health issues. I return to Alison Johnstone's question about how we ensure that we tackle health inequalities. It is partly a question of ensuring that the person gets to the right part of the system and sees the right person. We need to look at how we ensure availability for signposting to mental health services, which we will do through our investment of £10 million in mental health in a primary care setting. Part of that will involve utilising more effectively existing parts of the statutory and voluntary sectors, but additional capacity will be required, too. For example, Maureen Watt is considering how we can increase the resilience of mental health services in the school environment.

The link worker's role will be to ensure that the person gets to the right source of advice, and that

will depend on what their need is. Some of that will involve very early intervention, and some of it will be more complex in nature. The link worker could be the glue in making sure that the person gets to the right place.

**Maree Todd:** Hi there. I want to ask about a couple of issues. Data sharing has come up as an issue that presents challenges for the multidisciplinary team model that you have described. Will you tell us a little about some of the solutions that you propose for that?

I would also like you to address the impact that Brexit might have on our NHS workforce. I know that 5 per cent of the doctors who work in Scotland are European Union nationals and that 15 per cent of the social care workforce are EU nationals. I represent the Highlands and Islands region, and I have heard anecdotally that some of the island boards think that they have a higher proportion of EU nationals working in areas in which it is harder to recruit. That issue is causing a reasonable level of concern already. Will you comment on that?

**The Deputy Convener:** Would it be helpful if the cabinet secretary wrote to us about the legislative changes on data protection?

**Shona Robison:** I would be happy to do that. It is a big issue that we need to resolve.

**The Deputy Convener:** Absolutely. I am just mindful of the time.

**Shona Robison:** I would be happy to write with more information on the issue of data sharing.

The issue of EU nationals and Brexit is important. We want to keep people working here in Scotland, regardless of whether they are EU nationals. Brexit throws up some real challenges, but the message that I want to send out now and at every opportunity is that those people are welcome, we want them to be here working in our NHS and we want them to stay here working in our NHS. We will consider how we can help to encourage them to do so.

**The Deputy Convener:** I thank the cabinet secretary and the rest of the panel.

I suspend the meeting to allow for a changeover of officials.

11:49

*Meeting suspended.*

11:52

*On resuming—*

## Social and Community Care Workforce

**The Deputy Convener:** The third item on the agenda is an evidence session on the social and community care workforce. We welcome Shona Robison, Cabinet Secretary for Health and Sport, and, from the Scottish Government, Geoff Huggins, director of health and social care integration; Alan Baird, chief social work adviser; and Sarah Gledhill, sponsor team lead for the Scottish Social Services Council.

I invite the cabinet secretary to make an opening statement.

**Shona Robison:** Thank you for the invitation. I hope that committee members will recognise the importance of the Government's commitment to integrating health and social care to ensure that people have access to the right care, in the right place and at the right time.

As people in Scotland live longer, often with complex support needs, we must work innovatively and collaboratively with colleagues across health and social care, and with communities themselves, to ensure that services support people, as far as possible, to stay in their own homes and communities for as long as possible. We know that that is generally what is best for people's wellbeing, and that it is what people want.

Our new health and social care partnerships all became operational on 1 April this year; they have the real power to drive change. Having the ability to plan, design and commission services in an integrated way from a single budget enables them to take a more joined-up approach, to shift resources more easily to target preventative activity and to take more holistic approaches to care and support, which will improve the experience and outcomes for all the people who use the services or need support.

We spend nearly £4 billion each year on social care support, and it is vital that we use that resource in the most effective way to deliver the best outcomes for the people of Scotland. Health and social care integration provides us with the opportunity to do that and to be more creative and innovative in the way that we deliver care.

We know that investing resources in community services rather than acute settings and improving links between care in hospitals and care in communities improves outcomes. I recently announced our plans for East Lothian community

hospital, which is a good example of how the different care sectors can work together to ensure that care is joined up and delivered closer to home and family with facilities for day care services. We have already signalled our commitment to resourcing care in community settings by allocating a further £250 million from the NHS to health and social care partnerships to protect and expand social care services and deliver our shared priorities. That includes our commitment to enable the living wage to be paid to care workers who support adults from 1 October.

Services need to be fully flexible to meet a person's needs and empower them to co-produce and self-direct their support to make choices about how their care can best be delivered. That shift requires fundamental change across the whole system and culture, from decision makers to the front-line staff who provide care and support on a daily basis.

To achieve a transformational change, it is vital that staff are fully supported. Our statutory outcomes for health and wellbeing, which underpin integration, address the importance of staff engagement and support. Partnerships are required to publish annual performance reports that set out their progress in relation to the outcomes. As you have heard from others, the landscape for the social and community care workforce is complex, and we all recognise that we must work across all partners and stakeholders to ensure that we have enough people with the right skills to support the needs of people with a variety of needs in communities.

We are committed to ensuring that the entire workforce is fully supported. That is why, in addition to the investment that I mentioned earlier, we remain committed to the policy on upskilling the workforce. That policy is wider in scope than any similar policy elsewhere in the UK. When the policy was introduced, around 80 per cent of the workforce did not have any qualifications. Now, through the work of employers and bodies such as the Scottish Social Services Council and the Care Inspectorate, around 100,000 of the people in the workforce are registered and have or are working towards the qualifications required for their role, and their fitness to practice can be regulated. That is progress. We are also working with partners on the social work services strategic forum and the human resources working group on integration to support a range of actions to strengthen the workforce and demonstrate how much it is valued.

We are clear that we cannot do this work alone, so the committee's interest in the area provides a timely opportunity to consider the progress that has been made and the challenges that we need to work on together with all our partners, many of whom the committee heard from at its evidence session on 13 September.

**The Deputy Convener:** Thank you very much, cabinet secretary. We will now move to questions.

**Donald Cameron:** I have a specific question about Brexit. Annie Gunner Logan, who represents voluntary care providers, told us—I am speaking from memory—that, when she asked her staff about the implications of Brexit, they mentioned that it provided an opportunity to lessen the burden of rules on procurement and tendering. Do you have any observations about that?

**Shona Robison:** Whatever constitutional arrangements we have, there will always be rules on procurement and tendering because of the need for openness and transparency, and to ensure that due process is followed and seen to be followed in the spending of public money.

On the impact of Brexit, given where many of the workers in social care come from, I am extremely concerned about the potential loss of workers from other parts of Europe who support our care services, particularly in the care home sector. We should all be extremely concerned about that. Again, I take the opportunity to send the social care workforce the message that, no matter where they come from, their work here is valued and we want them to remain working here, whether that be in our care home sector or our care-at-home sector.

12:00

**Donald Cameron:** On that subject, the panel of witnesses that we heard from two weeks ago said that one of the problems was that it was hard to estimate the number of non-UK EU nationals working in the social care workforce. Is the Government doing anything to establish what those numbers might be?

**Shona Robison:** I will let Geoff Huggins respond in a second, but if you go round the care home sector in particular—this is also true, to some degree, of the care-at-home sector—and speak to the staff in care homes the length and breadth of Scotland, you will find that many not only in our social care workforce but in our nursing workforce have come from other parts of Europe. That is very visible to me.

Alan Baird probably has a bit more data and information on the numbers, but I do not think it unreasonable to say that the loss of that cohort of staff, who do a hugely important job here, would be a blow to the sector that we would want to avoid. That is why I am sending the message that we value them and want them to remain working here in the sector.

Alan, do you want to say a word about the make-up of the workforce?

**Alan Baird (Scottish Government):** As I think was noted in the meeting on 5 September, we do not currently know the number of people in the workforce who come from the EU and beyond, but I think that that is something that we will increasingly need to understand in order to look at the potential gap in social care.

**Shona Robison:** Did you want to come in here, Geoff?

**Geoff Huggins:** I want to make two points. First of all, Annie Gunner Logan made an interesting point about procurement, because part of the challenge that we face in delivering the living wage is the legal framework within which we can specify contract rates. There is therefore a question about what would happen next in the context of Brexit. The other component is that we do not know whether the next step beyond Brexit would be a reserved or a devolved matter, and if it were a reserved matter, how it would be handled in the broader context of UK policy on earnings.

We are certainly conscious of the issue in respect of non-UK nationals in the workforce and, in that space, we would also be careful about the degree to which that patterns in different ways across the country and how likely it is to affect different components of service delivery differently across Scotland, particularly—and I think that the committee has previously taken evidence on this—in island authorities as well as more remote and rural authorities, especially those in the north-east.

We are and will be discussing this area with the partners group, which comprises not only providers but Unison, and with which we have been working more generally on taking forward some of the reforms. The issue is right in front of us at the moment.

**Shona Robison:** I think that Sarah Gledhill is going to say something about data collection.

**Sarah Gledhill (Scottish Government):** As I am sure you know, the SSSC collects annual data on the social services workforce, and we are discussing with it whether we might be able to add a question that will enable us to collect more accurate information on this topic.

**The Deputy Convener:** Picking up on something that Geoff Huggins said, I wonder whether you can give us an update on progress in implementing the Scottish living wage across social care.

**Shona Robison:** Before Geoff Huggins comes in on that, I should say that people have been working hard across the partnerships to ensure delivery from 1 October, and I put on record my thanks to all of them for doing so. After all, it has been quite a big undertaking. A lot of hard work is being done, and I think that we are in a good place.

**Geoff Huggins:** As the evidence that you have heard previously suggests—I imagine that you are also hearing this separately—this is a remarkably challenging undertaking. We are working on it directly with the Coalition of Care and Support Providers in Scotland, Scottish Care, Unison and the Convention of Scottish Local Authorities; indeed, I spoke to CCPS and Scottish Care this morning to get an update from them and to share our understanding of what is going on. We are therefore working carefully across partners to triangulate what is happening in local negotiations and, from that, to get a national picture.

We know that good progress has been made in many areas; in other areas, negotiations are continuing. Part of the challenge is that it is not a question of simply finding the right number and then rolling out the policy; the process is built up of hundreds of local negotiations with individual providers, who have historically offered different terms and conditions to their workforces. It is not a small-scale undertaking.

On the basis of the work that we are doing, including with individual partnerships, we are confident that there is progress. I speak with chief officers and procurement officers regularly, so that I can understand what is going on and ensure that we deliver the commitment. It is clear that we are still resolving some issues locally. However, we are confident that we will meet the commitment that the benefit of the living wage will be achieved from 1 October.

**Colin Smyth:** I presume that lessons will be learned from the approach that has been taken so far. You have said that you will be working up to the 11th hour to ensure that everyone gets the living wage from Saturday.

The committee took evidence from Annie Gunner Logan, who pointed out that providers were not consulted on the implementation of the policy but read about it in the newspapers. What will you do in future to involve stakeholders in developing policy, to ensure that it is sustainable in the long term?

It is widely recognised that the Scottish Government's estimate of £37 million was very much an underestimate of the cost of the policy nationally. What assessment will you make of the cost of implementing the policy from 1 October, as we hope will happen?

I am keen for clarity on payment for sleepover shifts. Is it the Scottish Government's position that sleepover shifts should be paid at the living wage

rate? Will that be the case from 1 October? If not, when will that happen?

**Shona Robison:** Part of the £250 million that we have provided for social care is for the delivery of the living wage. It is an ambitious undertaking—Geoff Huggins outlined some of the complexities—but I think that there has been a willingness and a determination on the part of all partners to make it happen, because it is a good thing, which will encourage people to stay in—and, I hope, enter—the caring profession.

The complexity arises partly because the area is subject to negotiation by the local partners who commission and procure services. They are the ones who must deliver the mechanism for paying the living wage. We have provided the resources, but the mechanics of the approach must be delivered locally. Partnerships in some areas were further along the road towards the living wage than partnerships in other areas, so the distance to be travelled has been different in different areas, which has meant that different resourcing has been required in different areas. Things will become easier, I think, because we now have data that we did not have before, at local and at national level.

I think that the policy can be sustained in the long term. As I think I said to you during the parliamentary debate on health, our discussions with COSLA and partners in the care sector are partly about ensuring in the spending review that the living wage continues to be delivered. That is an important priority for us.

You asked about sleepovers. That issue is still being discussed, because of the complex way in which sleepover payments are made. Partners have asked for more time, and I understand that the unions have been party to the discussions to ensure that the issue is resolved. It will take more time to resolve that, and we will help and work with local partners to ensure that the discussions are taken forward as quickly as possible.

**Geoff Huggins:** You asked about lessons learned. As the cabinet secretary said, we have asked partners to use the existing system for retendering and renegotiating. We have taken four or five elements of learning out of that to think about for next year, because we will be looking to think about how to approach this as time moves on.

A key component is the change in the nature of the relationship between commissioning and procurement. Historically, this would have been a local government commissioned and procured service. It is now an integration authority-commissioned service and a local government-procured service. That gives us the opportunity to discuss how we might take forward the procurement differently now that it is separate from the commissioning role. That is a key change that has taken place under integration.

For some of the more niche providers in learning disability or mental health who provide across a number of integration authority areas, we are looking at whether we should be considering a lead procurer and at the challenges of similar providers being made different offers from adjoining authorities. We are learning the lessons: we talked about those with the chief officers when we met them 10 days ago, and it was on my agenda this morning for the discussions with Annie Gunner Logan and Donald Macaskill.

On the cost assessment, the information that we lodged in the Scottish Parliament information centre at the end of 2015 was very explicit about the presumptions that had been made. Some of those presumptions were questioned when the committee last met. It would have been challenging to have involved the providers in the negotiation between the Deputy First Minister and COSLA on the local government settlement, although we understand their frustration about that.

As part of that process, we invited local partnerships to consider what they believed the local cost would be and offered our information as support to the process by which they considered the use of the £125 million. Although we put information into the system, we did not say, “This is the figure”. We gave a figure based on particular presumptions and the knowledge that we had, and we invited local partnerships to make their own assessment of the appropriate cost. Most appear to have done that adequately.

We are also talking about the process of involvement for the next round. We think that the process that we have built with the partners group, which involves the Scottish Government, COSLA, CCPS, Scottish Care and the unions, is a good methodology for future years.

**Colin Smyth:** I understand fully the complexities of having 7,000 social care providers across Scotland and 31 IJBs. We have a national framework for care homes. Is any consideration being given to a national framework for care at home?

**Geoff Huggins:** That is probably less straightforward. Although the majority of the service is for older people—it covers things such as personal care and assistance with daily living—it becomes more challenging to consider the idea of a single rate that covers a range of other complex services such as those for substance misuse, learning disability and mental health. There are also different ways in which services are stitched together locally between health and care,

which means that the burdens that fall on social care and health services might be different depending on where you are.

As part of the reform process, we are looking at those questions, but the issue might be less straightforward than it is for residential care. Indeed, the work that we are doing on residential care is raising the question of whether we need different approaches for the various forms of residential care. Ultimately, the objective is to provide and fund services in a way that supports the different needs of individuals, rather than reducing them to a common minimum.

**Alex Cole-Hamilton:** One of the biggest impacts on the workforce planning environment, aside from that of integration, has been from the advent of self-directed support. I would like to hear the panel's reflections on how that has impacted on workforce planning. A number of us have received briefings from health boards about provider behaviours in response to self-directed support that have not been entirely helpful. Will the witnesses reflect on the impact of self-directed support on the workforce planning agenda in social care?

12:15

**Shona Robison:** I was the Minister for Public Health when we were in the initial stages of taking forward the concept of self-directed support and during the passage of the legislation that followed. Out of everything that has been done, that has the potential to be one of the most innovative programmes and concepts. It is all about empowering people, putting the person in the driving seat of their care and ensuring that they are involved in building the services around them, rather than having services provided to them that do not meet their needs. The concept is fantastic, but to be honest it is work in progress. We have provided a lot of support to make it happen and resources have gone in to ensure that we embed the whole process of self-directed support across the social care sector to build the workforce, and to ensure that anyone who wants access to self-directed support to deliver the care that they need can have access to it.

We are in a better place than we were previously with the whole culture of accepting self-directed support. Initially, there may have been a bit of resistance, because people thought that it might threaten the statutory service model in some way. That is less the case now—people have accepted that it is a good option and not a threat to existing services but an enhancement of them.

Geoff Huggins may want to say more about that.

**Geoff Huggins:** We have found self-directed support being used in innovative and novel ways, particularly in rural communities. One of the examples that I often give is the Boleskine Community Care model, from the banks of Loch Ness—an area where it was difficult to recruit a social care workforce or persuade people to travel the required distance. Instead, people in the community were identified who were prepared to do a few sessions a week using self-directed support to provide care for others who lived in their neighbourhood, and that worked effectively.

Alex Cole-Hamilton identified provider behaviour as an issue, and I will be interested to see what happens in that regard. I would assess it as being largely driven by the previous approach around compulsory competitive tendering. We will see whether that is a continuing factor as we move away from the focus on price towards quality being the dominant factor, along with pay increases and the values of contracts changing. There is a question as to whether that behaviour, as a reaction to CCT, will continue to be as forceful. The comments in the Auditor General for Scotland's report last week on the impact of CCT are helpful in that regard.

The bigger challenge with some services, such as day services, is the increasing diversity in the support that people are looking for. That will be difficult to work through, but we need to do it.

**Shona Robison:** The Scottish Government has invested £58.6 million in the transition to SDS between 2011 and 2016-17, and some of that has been around building the workforce and the innovation fund. Alan Baird can tell you more about that.

**Alan Baird:** I have spent quite a lot of time in recent months visiting large providers such as local authorities and smaller organisations in the third sector, and I have met a cross-section of front-line social workers to hear about their experiences. We are halfway through a 10-year strategy. As the cabinet secretary has said, it is a complex undertaking. The Government provided a considerable amount of money to put in place the right infrastructure and, as a result, we have made really good progress.

Those who are in receipt of self-directed support—people who are making the right opportunities from the choices that they have—are seeing their lives change in innovative ways. However, national providers get really frustrated about the number of sets of forms that exist across Scotland. National organisations work with a number of local authorities. For example, a provider that works with 10 local authorities can expect to get 10 sets of forms, which is time consuming. There is a sense of frustration, given the current resources and the level of self-directed support that there ought to be.

We are making really good progress. Those who are in receipt of self-directed support sometimes say that there is an issue when the amount of money they get has been reduced. Some see that as part of the austerity that local authorities face. The other side of that coin is that self-directed support is working well and that, because the needs of the individual have changed, they no longer need the level of provision that they may once have had with self-directed support. We are learning a great deal as we progress and we need to use the coming months and years to pick up on some of the emerging issues.

**Alison Johnstone:** Colleagues including Maree Todd and Donald Cameron have raised the issue of the potential impact of Brexit on the workforce. We are discussing the move to care in the community, but the whole thing is predicated on our having enough social care staff.

The SSSC spoke about a survey of employees that tried to understand better where people come from, but it seems that there is a dearth of definitive data on the number of EU nationals working in the NHS and in social care. What steps is the Government taking to establish that number and what contingencies are being put in place in case EU nationals do not have an automatic right to remain after EU withdrawal?

**Shona Robison:** That is a little easier with our medical and nursing workforce, because we have the data, as do the regulators. Therefore, we can provide more definitive information about the medical workforce, and we have done so. The numbers are a concern.

As you heard earlier, the situation is less clear with the social care workforce, because the gathering of information is work in progress. As Sarah Gledhill said—she might want to expand on this—we are looking at including additional questions on the workforce survey to try to gather more information about whether people are EU nationals or, indeed, where they come from more generally. That would be helpful.

I ask Sarah whether we can give a timeframe for that.

**Sarah Gledhill:** Over the next couple of months, discussions will take place with the SSSC on whether we can change the data collection for the next round of data. We are also considering whether we need to do something more urgently or in the shorter term. The SSSC publishes data retrospectively, so there is a bit of a time lag between the data being ready to publish and the year that it refers to. We are looking at whether we need to do an exercise shortly, and whether we should include a further question so that, going forward, we collect the data needed to answer that question.

**Shona Robison:** Perhaps we could write to the committee with an update.

**Sarah Gledhill:** We could do that, once we are clear about what we will do. That would be fine.

**Alison Johnstone:** That would be helpful.

**Miles Briggs:** I have a question about care home places. Audit Scotland has said that Scotland will require an estimated 20,000 additional care home places by 2030. The answer that I received in response to a parliamentary question shows that Scotland has lost 3,600 places. We have heard from private sector providers that they are finding it difficult to sustain the service. What work is being undertaken to ensure that Scotland is adequately supplied with the care home places that we need?

**Shona Robison:** The make-up of care home places and what we use care home places for have changed over the years. We have worked closely with Scottish Care on that change.

I was a home care organiser in a previous life, and it was not unusual for people to go into a care home setting when they were still quite fit. That was for a variety of reasons; it was a different culture. People's ability and desire to stay at home have changed—their outlook has changed. Without doubt, the demand now is for people to remain living in their own homes with appropriate support.

That has led to a change in the care home sector. There are now fewer places and there has been a change in what those places are used for. Our discussions with the care home sector have been about needs now and in the future. We will need more intermediate care and we are looking at what the sector can provide. There are great examples of that. We have hugely expanded the number of intermediate care places, many of which are located in a care home environment. That helps to put the care home sector on a more sustainable footing and provides what is needed. It also provides a service that is a step down and potentially a step up—although that is less developed—between home and hospital. That is a really important development.

It is fair to say that the people who end up in permanent care home places now have far more complex needs than previously. A lot of people have complex needs with dementia, which has meant a change in the number of places that are provided and in the care staff ratios that are required. Those are not necessarily negative developments; they are a recognition of the changing needs of the population. There is change

in what people demand and the sector needs to adapt to meet that, and we want to help it to do so.

**Miles Briggs:** The evidence from NHS Greater Glasgow and Clyde was that it is using the private care sector in Glasgow to help to tackle delayed discharge. There was a concern that the potential loss of private sector beds could have an impact on the acute setting. We need to be aware of the unintended consequences of Scotland losing places.

**Shona Robison:** We need to have the right number of places in the right areas to meet the needs of the population. All I am saying is that that is changing. With regard to that development in Glasgow, I have visited one of the care homes that is providing that intermediate step-down facility. It is a fantastic service that meets the needs of the acute sector to reduce delayed discharge and provides stability and sustainability for the care home sector. It is different from the role that the care home sector has traditionally provided, but the sector has embraced that well.

**Geoff Huggins:** The Glasgow example is interesting, as it shows leverage. By working in that way, more people have returned home than would have been the case historically, which is what people say that they want. The Auditor General's report was careful in saying that it was about what would happen if nothing changed and things continued as they are. Throughout, the report stunningly makes the case for reform. It says that there is a need to think differently about how we approach care and how we meet people's needs.

With each of the partnerships that we are talking to at the moment, we have identified the idea of using more hours to support reablement and step-down. An increase in people's capacity to continue to care for themselves is core to the changes that we are seeing.

**Shona Robison:** Reablement is really important. In my previous life as a home-care organiser, a person's needs would often change because of a fall. They would come out of hospital and the things that they had taken for granted and done for decades for themselves would suddenly be done by somebody else. With reablement, they can get back those independent skills. The thought processes on that have completely changed, for the better.

**Sarah Gledhill:** To clarify the figures on the number of care homes, although the total number has fallen by quite a lot—17 per cent in the 10 years since 2006—the number of registered places has fallen by only 3 per cent and the number of residents has fallen by 4 per cent.

12:30

**Miles Briggs:** The figures that the cabinet secretary provided in a written answer to my question suggest that there are now 42,026 places in Scotland, which is down by 3,695. Given what Audit Scotland has said about an extra 20,000 care home places being required, there is concern that the direction of travel on the number of places is down.

**Shona Robison:** But it is about what we use the places in the sector for. There has been a big increase in the number of hours of care at home provided each week. That care is going to fewer people, because the complexity of the needs of people who remain in their home has increased, so their packages are greater and the number of hours overall has increased. We are seeing a shift towards people remaining in their own home for longer, so the type of service that the care home sector provides is changing. We want to work with the sector to help it to provide a sustainable service that meets the needs of an ageing population.

**The Deputy Convener:** I will ask one final question before we finish, because it is a really important one. One of the most valuable and informative sessions that the committee has had was the one a few weeks ago with social care workers from residential care and home care. How do we make a career in care more attractive and a more valued career choice in our society?

**Shona Robison:** That is probably the key question and the most important one. We must ensure that we value the caring role and the people who work in the care sector, whether it be in people's homes or in a care home. The living wage and what people are paid for the role are important components, as are some of the surrounding terms and conditions, so it is important that we work with the sector to try to improve those. It is also about career opportunities and progression. In the world of integration, we are seeing some innovative ways of linking opportunities in health and care so that, for example, should someone who comes into the care sector have an ambition to end up working in a regulated profession, they can make the transition in a more coherent and structured way and there is a pathway. That will not be for everybody but, for many, it would be quite an attractive way to come into a regulated profession such as nursing.

We can furnish you with examples from across the country. For example, NHS Western Isles is taking the approach that I have described because it recognised that it needed to develop and deliver its own workforce, as it could not wait for people to pitch up from elsewhere to meet the needs of its population. One way that NHS Western Isles is

doing that is to encourage people in its communities to think about health and care as a profession and to provide pathways through one into the other, should that be what someone wants to do. We need to get better at that. We are working with NHS Education for Scotland to develop more coherent pathways through care and health and to share the training opportunities that exist in the NHS so that care staff can link into them.

**Alan Baird:** I draw members' attention to "Social Services in Scotland: a shared vision and strategy 2015-2020". One of its four sections is on workforce and—as the committee heard two weeks ago—it is about valuing the workforce. It is also about how we recruit and retain much better. A lot of work is going on because we anticipated as a sector—some of the people who the committee spoke to two weeks ago are part of the process—the need to take forward work on the quality of social care in Scotland and the value that is placed on the workforce.

**The Deputy Convener:** I thank the cabinet secretary and the other witnesses for their time this morning.

12:34

*Meeting continued in private until 12:46.*

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