OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 8 November 2016

Session 5

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CONTENTS

Col.

SECTION 23 REPORT 1
“NHS in Scotland 2016” 1
RECRUITMENT AND RETENTION 20
MENTAL HEALTH 33

HEALTH AND SPORT COMMITTEE
10th 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:

Michael Gowan (Scottish Youth Parliament)
Paul Gray (Scottish Government)
Fiona McQueen (Scottish Government)
Sophie Pilgrim (Kindred Advocacy)
Shona Robison (Cabinet Secretary for Health and Sport)
Shirley Rogers (Scottish Government)
Rachel Stewart (Scottish Association for Mental Health)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 8 November 2016

[The Convener opened the meeting at 09:35]

Section 23 Report

"NHS in Scotland 2016"

The Convener (Neil Findlay): Good morning, everyone, and welcome to the 10th meeting in 2016 of the Health and Sport Committee in the Scottish Parliament's fifth session. I ask everyone in the room to ensure that their mobile phones are silent. It is acceptable to use mobile devices for social media, but I ask people not take photographs or film proceedings.

The first item on the agenda is an evidence-taking session on the Audit Scotland report "NHS in Scotland 2016". I welcome to the committee Shona Robison, the Cabinet Secretary for Health and Sport, and Paul Gray, who is the director general of health and social care and the chief executive of NHS Scotland.

I invite the cabinet secretary to make a brief opening statement.

The Cabinet Secretary for Health and Sport (Shona Robison): Thank you very much, convener. As I made clear in my parliamentary statement last week, the Audit Scotland report has provided a balanced overview of the national health service and makes several recommendations, which we accept in full. I welcome having a further opportunity to discuss the report this morning.

Our investments and achievements are recognised in the report: funding is at a record high of close to £13 billion; staffing is at its highest-ever level; and health, patient safety and survival rates are all showing improvements. However, as I highlighted last week, to equip health and social care services for the future, we must reform as well as invest. We acknowledge the demands and pressures, which is why we will continue to drive forward our significant programme of transformational change. By the end of this year, we will set out a transformational change delivery plan for the integration of health and social care, the national clinical strategy, the public health strategy, realistic medicine, workforce recruitment, supporting population health and achieving the 2020 vision.

Audit Scotland highlights the point that we need to make a shift from relying on treating people in hospital to supporting people with better care in their own homes and communities. That is what we intend to do. Over this parliamentary session, we will increase health spending by almost £2 billion and invest an additional £500 million in primary care. That will mean that, for the first time ever, half of the health budget will be spent in the community delivering primary, community and social care. The committee will also be aware that we are investing £200 million in elective and diagnostic treatment centres to address the changing demographics of our nation over the next 20 years, particularly the likely increase in our elderly population.

It is important that we focus on outcomes for patients and that the mechanisms that we use to measure performance better reflect those outcomes. Our arrangements for a review chaired by Sir Harry Burns will ensure that our targets and performance indicators lead to the best outcomes for people who are being cared for, whether in hospital, community care or social care.

Audit Scotland is supportive of our transformational change programme. It is now important that we work together across the Parliament and with our colleagues in health boards and local government to make it happen. Through that approach of continued investment and reform, we will set the basis for delivering the 2020 vision and our longer-term strategy up to 2030. That will ensure a safe, sustainable and person-centred NHS for the people of Scotland.

Alison Johnstone (Lothian) (Green): The committee is aware of your proposal to present by the end of the year the plan to bring about that transformational change. The Audit Scotland report says:

> "it is not clear yet what number and levels of staff will be required until further work is done on testing new models and a clearer plan is in place."

It points out that the workforce plan that the Government has published

> "is high level and does not outline the workforce requirements to deliver the 2020 Vision and the National Clinical Strategy."

The committee recently heard from a representative of the Royal College of Midwives, who stated:

> "The NHS is running a third test of its workforce planning tool for midwives. If it is having a third run to test the tool, it cannot tell me that the tool is robust."—[*Official Report, Health and Sport Committee*, 1 November 2016; c 28-29.]

The Royal College of Midwives also suggested that boards had done some previous workforce planning in isolation, without getting input from professionals on the ground. What is happening now to develop the workforce plan with all those from whom we have heard evidence?

Shona Robison: We very much want to involve all the stakeholders you mention and others in the development of both the regional and the national workforce plan. Workforce planning has been a key part of the NHS for a long time, but it has tended to be done at a board level. We have worked with boards to ensure that they land their workforce plan as accurately as possible, but we recognise that we need to take a regional and national approach to workforce planning in a way that we have not previously done. That is the new part of the approach.

However, that cannot sit in isolation, which is why the delivery plan that I have talked about this morning—and to which Audit Scotland referred—ensures that all the strands have to be brought together. We cannot look at the workforce in isolation—the workforce plan has to be overlaid by the financial plan, the national clinical strategy and realistic medicine. It is about bringing all those elements together in a coherent way that will set out for the next five, 10 or 15 years what is required to make some of these changes. For example, a key part of the workforce plan will be to ask what primary care workforce will be required to make the required shift. That is not only about GPs but about advanced nurse practitioners and allied health professionals, and I suspect that there will be some new roles. It is about bringing all that together to make sure that the workforce is there in sufficient numbers as we shift the balance of care across. That is the new part.

It is almost as much of an art as a science to get workforce planning accurate, because things change. A board may have a workforce plan that it thought was robust, but the needs of the local population may change so it can find that it needs to make changes to the workforce plan. The regional and national approach is right, because we can project as far as we can what the changing needs will be and what the workforce requirements will be, particularly in primary care.

Alison Johnstone: Donald Macaskill, the chief executive of Scottish Care, told the committee that the vacancy level for social care nurses has reached 28 per cent. I appreciate what you are saying about the Government perhaps having a wider vision about which professional vacancies we need to fill. Will there be greater national direction on previously non-controlled subjects?

Shona Robison: I think that there will need to be greater national and regional direction than there was previously. Social care is more complex because, in the case of care at home, local government is the employer, so workforce requirements across health and social care will need to be integrated through our integrated plans and the integration joint boards. It is not just about health; it is also about the social care dimension.

I know that the Royal College of Nursing has raised concerns about the nursing component in nursing homes. It has always been a difficult area to recruit to for a variety of reasons. We are keen to work with the RCN to look at whether we can enhance the career opportunities for nurses working in nursing homes by enabling them to take advantage of training opportunities and career development in the NHS. We need to look at more imaginative ways of trying to encourage nurses into the nursing home sector if we are going to stabilise that situation.

Alison Johnstone: Jill Vickerman of the British Medical Association last week expressed concern about how vacancies are recorded. To understand fully what vacancies exist, would it not be more sensible to include posts that are currently being filled by locums and posts that have been advertised but are no longer being advertised? I think that Jill Vickerman made the point that if, for example, staff on a ward know that there are 10 vacancies but only three are being advertised, that will have an impact on morale. I think that a clearer system would be appreciated by all.

09:45

Shona Robison: Obviously, there has been a standardised way of recording vacancies, and I understand the point that Jill Vickerman and others have made.

It is very challenging to fill vacancies. That is not just a Scottish problem; it is very much a United Kingdom and international one in some specialties. A lot of work is going on to try to attract people to those posts, by making those posts more attractive or offering them across more than one site.

We are also looking at whether posts that are continually filled through locum or agency staff can be dealt with in a different way. In the case of agency staff, the chief nursing officer is looking at converting some agency spend into substantive posts rather than relying on agency and bank nurses. If a shift rota in a hospital continually uses a high level of agency nursing, an analysis of that might determine that it is better to convert that into substantive posts. Discussions about that are going on. It is more difficult with locum medical posts. The medical bank tries to help with short-term vacancies, but that is a bit more challenging.

We are happy to speak to Jill Vickerman and others about how we will take the matter forward in our workforce plans, and we will listen to what they have to say.

Tom Arthur (Renfrewshire South) (SNP): Good morning. My question is a supplementary to Alison Johnstone's question on workforce planning. What impact has Brexit had on the

deliberations and the work that is under way on workforce planning? In particular, given the UK Government's failure to assure the status of European Union nationals and, indeed, its description of EU nationals as a "bargaining chip", are any contingencies being factored into workforce planning for a hard Brexit?

Shona Robison: Those issues will be looked at in more detail in this afternoon's debate. There are concerns about the impact on our medical and nursing workforce in particular. I think that around 6.8 per cent of doctors currently have EU status, and there would be a significant dent in the workforce if we were not able to retain those doctors to work in Scotland. We want them to continue to work here as well as the nurses and the social care workforce who have come to train and work in Scotland. We very much value them.

To give reassurance to students who are already studying here, those who are about to begin their studies here and those who are applying to study here from 2017-18, we have made a commitment that they will continue to enjoy free tuition for the duration of their studies at our medical and dental schools. Unfortunately, we cannot provide assurance on their future rights to remain here to train and work. That could impact on their future career decisions when they are deciding where they want to go.

The issue is important and is part of the negotiations. We will have more to say about that later today. It is important that the key message is that we very much value the contribution that those people already make in our health and care services.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, cabinet secretary. Thank you for coming to the meeting.

The Audit Scotland report is quite uncomfortable reading for all of us who have a stake in the healthcare profession. However, the Government met one target, which related to the treatment of drug and alcohol cases, particularly at the acute end. I congratulate the Government on that, but perhaps that is a case of what it gives with one hand, it takes away with the other.

Last month, we heard from Rob McCulloch-Graham, who is the chair of the Edinburgh integration joint board, that the impact of the 22 per cent cut to alcohol and drug partnership funding in the previous Scottish Government budget would be measured out as a £1.3 million year-on-year loss to services in the drug and alcohol field in Edinburgh alone. To my mind, that is a fire sale. We will see the impact of it over not just years but decades, and not just in Edinburgh but everywhere in Scotland where drug and alcohol misuse is a problem—we have already seen a measurable rise in HIV cases in Glasgow.

I would like the cabinet secretary to share with us her reflections on the Audit Scotland report and the fact that, although we might be meeting the acute treatment targets on drug and alcohol misuse, we will be messing up the end game.

Shona Robison: First, I will make an overall comment about the targets. It is important to say that the 31-day cancer target was missed by only 0.5 per cent. That figure represents people—about eight patients in total—and we have to strive to do better than that, but it is important to remember the context in which Audit Scotland put that missed target.

I recognise that we have a challenge on out-patients. That is why we are bringing forward a programme of additional investment in that area and, importantly, implementing a transformation programme in out-patients services. We need to better manage the out-patient capacity.

On alcohol and drug partnership funding, you will be aware that we wrote to boards to ask them to support the funding levels of ADPs. Some have done so and some have not. We will continue to work with those boards and discuss with them ways in which we can ensure that the delivery of alcohol and drug misuse outcomes—which are what is really important—continues to be as good as it is. It is important to note that many partnerships have delivered well over what they were asked to deliver and have performed extremely well, and that there has been a substantial investment in alcohol and drug misuse funding. We have also said that we need to review the priorities of ADPs and examine their performance more generally, and we might want to discuss with ADPs some changes that they could make and focus on the outcomes for the next period of time.

As I have said to the committee before, we will continue to talk to boards about ADP funding, we will continue to look at what ADPs do and we will continue to examine the outcomes and ensure that the ADPs are in a position to deliver those outcomes.

Alex Cole-Hamilton: I am encouraged to hear that the issue is still very much on your radar. However, a cut of 22 per cent in the overall budget for alcohol and drug partnerships can lead only to a withdrawal of service in some areas, as we are seeing in Edinburgh. It is fine for you to go to the local health boards and the integration joint boards and tell them to make up the shortfall somehow, but it is a different matter to make that materialise. That loss of service will undoubtedly lead to a proliferation of drug and alcohol misuse and to long-term addictions going untreated, which I think

will have a material impact on the treatment targets. If we see an increasing demand for acute treatment, those targets will be missed in the future. Can you explain to us the reasoning behind the original cut to the ADP budget in the previous Scottish budget?

Shona Robison: The ADP budget was an amalgamation of health and justice funding, as I am sure that you are aware.

To give a little bit of context, I should point out that, since 2008, the Government has invested more than £630 million in tackling alcohol and drug misuse, which is a significant investment. We made clear to boards that we expect the outcomes to still be met and that they will need to ensure that that happens. We suggested that boards should maintain the level of funding through their resources and, of course, boards have been given above-inflation increases this financial year. However, regardless of how they do it, we will still require ADPs, with the support of boards, to meet their outcomes.

The review that is under way with key stakeholders is part of that. It is examining how we can support boards to do that. There may be a need to focus some of the alcohol and drug partnerships more around some of those outcomes. ADPs are very varied in what they do and how they operate, and we need to bring a bit more standardisation to that.

The bottom line is that outcomes matter. The funding is important, but it is the outcomes for that funding that are most important. We have been clear that those outcomes still require to be delivered. That may be through the level of funding that they have been allocated—and if they can do that and deliver the same outcomes by doing things in a different way we will look at that—but if not, we will require and expect boards to support the ADPs in delivering the outcomes. The outcomes still require to be delivered.

Alex Cole-Hamilton: I think that everybody around the table would absolutely agree that the outcomes matter and still need to be delivered, but your answer, cabinet secretary, has the feeling of a premiership football manager telling the team to deliver the same result when three players have been sent off the pitch. What we are talking about here is a 22 per cent loss in resources. I say with respect that you did not answer my question about why the Government has felt that it was okay to withdraw that 22 per cent of funding.

Shona Robison: We have asked boards to support that funding at the same level as they did previously. The budget was an amalgamation of health and justice resources, and we have asked boards to supplement the funding.

Outcomes are the most important thing: funding is important, but most important is what is delivered with that funding. Waiting times have been hugely reduced, with 94 per cent of people now being seen within three weeks of being referred. The national 90 per cent local delivery plan standard is being routinely met, and drug taking in the general population is falling. It is important that alcohol and drug partnerships deliver their existing outcomes, but they should also look at what the outcomes should be in the light of all of the information. As part of the review of targets and indicators more generally, what do we and ADPs think they should focus on in the coming period in the light of that shift in behaviour? There are still challenges, particularly among some of the older population, so we need to make sure that the substantial resources that are still going into drug and alcohol treatment are delivering the right things and refocusing on where the biggest problems remain in the light of that population behaviour change—which is, of course, a good thing.

The Convener: We have heard several times this morning that outcomes matter. According to the Audit Scotland report there is a funding crisis, workforce problems are impacting on patient care, agency use and vacancy rates are up and seven of the eight key targets or outcomes are being missed. If outcomes matter, we have a problem. How can it be, when seven of the eight targets are being missed, that further budget reductions are being regarded as “efficiencies”?

Shona Robison: Well, I am sure—

The Convener: I am sorry. Could I direct that question to Mr Gray, first? Mr Gray is the senior official with the NHS in Scotland and is obviously, along with the cabinet secretary, accountable for it, which is why I want to bring him in.

Paul Gray (Scottish Government): Efficiency savings have been delivered year on year by the NHS in Scotland. That is not a new proposition. So that I answer your question appropriately, what are you referring to specifically when you say “budget reductions”? The budget has gone up each year.

The Convener: Boards they tell us that they are making very significant reductions. I do not want always to harp on about NHS Lothian, but it tells us that it has made something like £68 million of reductions this year. If it is already missing seven out of eight targets and is required to make another £300 to £400 million of reductions in the next three to four years, how on earth can those be called “efficiencies”?

Paul Gray: That is because we look to boards to transform the services to deliver them more efficiently and to improve the outcomes that they deliver.

10:00

From memory, I think that NHS Lothian's uplift was 6.4 per cent. I would be happy to provide accurate information to the committee if I have made a mistake, but it had a funding uplift. We have put in extra money to NHS Lothian over the past two years to bring it closer to NRAC—NHS Scotland resource allocation committee—parity. It is not unreasonable for the public to expect the NHS in Scotland to become more efficient year on year. That is why the programme of transformational change that we have in train is so important. The cabinet secretary will provide further detail to Parliament by the end of the year, and I have undertaken to write to the Public Audit and Post-legislative Scrutiny Committee by the end of the year confirming our framework for change, as requested in Audit Scotland's report "Changing models of health and social care".

It is not unreasonable to ask boards to make efficiency savings. Their budgets have not been cut. I am happy to say something about the eight targets if that would be helpful.

The Convener: We might come to that. Almost every witness who has come before us has raised issues about cuts to services. The only people whom I hear saying that there are no cuts to services are senior managers in the NHS. If we have the highest-ever level of investment in the NHS, as has been stated, do you regard the "NHS in Scotland 2016" report as a glowing endorsement of management of that record investment?

Paul Gray: I am not looking for glowing endorsements, Mr Findlay. As the cabinet secretary said, it is a balanced report, and we have accepted its recommendations. Among the recommendations is one on the importance of sustained transformational change, which is fundamental to delivering a safe, person-centred and effective health service.

The Convener: I will ask one final question on the issue. What comment do you have for patients who have been waiting longer for treatment than they should because seven out of the eight targets have been missed?

Paul Gray: I apologise to patients who wait longer than they should. I have done so in the past, and I regard it as appropriate and proper that I do so. We do not seek that patients wait longer than the targets that we have set, but, if I may say so, as far as I can determine—I have done some research—we are the only country in the world that tries to meet all those eight targets. I am happy to have stretch aims: It is part of our approach to improvement to set ourselves stretch aims and to do all that we can to transform to meet them. The cabinet secretary referred to Sir Harry Burns's review. Now is the right point at which to review whether all the targets that we have are delivering the outcomes that we want. In the meantime, if we are not achieving what we said we would achieve, I apologise to those who have not been seen within the target time.

Shona Robison: We were elected on a manifesto commitment to increase the health revenue budget by £500 million more than inflation by the end of this session of Parliament. That was higher than any other party's proposal. No matter who was in government and putting forward a prospectus for Parliament, that is against a backdrop of increasing funding and increasing demands. For example, out-patient demands have been increasing over the years, but despite those huge increases, most people are being treated within the 12-week target for a first out-patient consultation. On in-patient waits, in quarter 2 of this year 91.2 per cent of in-patients were treated within the 12 week treatment-time guarantee. That is not good enough—we want everybody to be treated quickly—but it is important to make the point that the vast majority of patients are treated quickly.

We need to ensure that, through our transformation programme, we improve performance in a sustainable way. That will be done through, for example, our out-patient transformation work; our out-patient system is not as efficient as it could be. We need to ensure that capacity is used as effectively as it can be.

There is also the work that is being done by Sir Harry Burns. There has been political consensus for many years on this—spokespeople of all the political parties have, at one point or another, said that we need to ensure that the patient outcomes that we measure reflect the patient experience more accurately. Sometimes, our targets are more input-based than outcome-based. I accept that criticism, and I have asked Sir Harry Burns to look at our whole system of what we measure and why, in order that we can capture more accurately what the patient experience is. That is the work that we are doing.

The Convener: We are short of time this morning, so I ask that answers be as brief as possible. Thank you.

Donald Cameron (Highlands and Islands) (Con): Good morning to you both. I return to workforce planning. We use the phrases "workforce plan" and "workforce planning" a lot. I have a factual question. Is there a document or spreadsheet in NHS Scotland—a master plan—that shows across all disciplines current staffing and vacancy levels, predicted vacancies and recommended staffing levels in 2017-18? Does such a master plan exist physically?

Shona Robison: It does, in that each board has that level of information and we have the information nationally. Also, the Information Services Division of the NHS in Scotland produces a lot of statistical information. The information is there.

The new bit of the regional and national workforce plan brings all that information together—what the picture is in the here and now and what it is projected will be required regionally and nationally in more granular detail. The workforce is probably going to change more than we have ever seen before. That requires us to make sure that, for example, in the primary care workforce we do not just produce more nurses and doctors in the specialties that we have, but try to land the numbers that are required as accurately as we can. Obviously, the nursing and medical workforce numbers and the training places all try to reflect what the needs of the service will be.

The work is different because it is about shifting the workforce into more primary and community care-based services. The workforce and what it looks like need to change. That is a new approach, and we need to take a national perspective on it.

Donald Cameron: What is not new, surely, is the need to project. You must have needed to project in 2010 and 2015—you must have some idea of what workforce you will need in 2017, 2018, 2020 and so on.

Shona Robison: Of course we do. We are able to project the number of nursing, midwifery and medical training places that will be required based on analysis of the service's needs. It is quite difficult to land that number 100 per cent accurately, but our workforce colleagues work very hard with boards to try and make sure—whether for undergraduate or for training places—that we land as accurately as possible the needs of the service, going forward. However, we will be in different territory in the next five, 10 and 15 years, because the services are going to change so dramatically, particularly because of the shift to primary care. That requires us to look in far more detail at how we create a new primary care workforce.

Richard Lyle (Uddingston and Bellshill) (SNP): Good morning, cabinet secretary and Mr Gray. You have this morning used the buzzwords, as I call them, "transformation programme", "reconfiguring services" and "local services".

Things move on and we have to change and look at how we can do things better. Do local health boards do enough to explain what they are doing and why they are reconfiguring services? Too often the Scottish Government gets thrown at it the claim that it is concentrating services. When boards make decisions that local politicians do not like, they then ask the cabinet secretary to call in those decisions. Is there a better way of informing the public why services are being reconfigured, moved, concentrated or improved?

Shona Robison: I think that some boards are better than others when it comes to service change proposals. Over the years, some boards have consulted the public in a good and meaningful way, with the result that, regardless of whether everybody liked the changes that were proposed, people have been more accepting of them because there has been proper consultation. There are also cases in which the process has not been handled quite so well.

However, the point is that boards will always look at the needs of their local populations. Sometimes service changes happen quickly because of patient-safety concerns or because inability to recruit key staff makes a service unsustainable. That has ever been so over the years.

I guess that what is new is that we now have the national clinical strategy, which provides the framework and blueprint for what services ought to look like in the future—from the more specialised services, which might have a more regional delivery focus, to what it is reasonable for people to expect their local hospital to provide, which will still be the majority of services. It also covers what more can be done in primary care—I am talking about services that, at the moment, might well be provided in secondary care, but which do not necessarily need to be.

The national clinical strategy is quite new. We have never had a blueprint for clinical services that lays out in that way what the vision should be. Obviously, we need boards to translate that locally and to make sure that what they do and the changes that they make are in line with that national policy.

Richard Lyle: I go along to some of the information meetings that the health board in my area holds, at which it tells us what it is doing. It annoys me that when the stories come out in the paper they are entirely different, and so the public perception is entirely different. What can boards do to improve the situation? Should they have more meetings, more social media coverage or more adverts?

Shona Robison: All those suggestions might be justified and relevant. Communication is key. Boards must be able to set out not just why they want to make changes, but what the new service will look like. Describing and demonstrating what a new service will look like—which is not always easy—is sometimes the missing bit. Quite often, when we go back and talk to the public and

patients once a change has happened, they think that the new service is better, but they might not have thought that it would be when the change was proposed.

Change is difficult—that will always be the case—but it is required. We are investing £500 million of additional resources in primary care and shifting that resource from secondary care, so change is necessary. I do not know what people think shifting the balance of care means, other than doing less in the acute sector and more in primary care. That is what it means, which means that services need to change. Perhaps someone here could tell me how else we can manage to invest that extra £500 million in primary care.

That is what will be done, but we must ensure that the public come with us on that journey and that they can hear about how much more can be done at their local health centre, which will avoid their having to travel miles to their local hospital or to a hospital much further away. I think that the public will get a better service, but we need to explain that.

Richard Lyle: Thank you.

Colin Smyth (South Scotland) (Lab): I come back to the issue of efficiency savings, which I think relates to Richard Lyle's point about taking the public with us when it comes to transformational change. We must be honest with the public on what is happening with regard to savings. The key message from the Audit Scotland report is that funding has not kept pace with rising demand. That is a fact. As the report says, health boards are having to make "unprecedented levels of savings". They had to make savings of £291 million in 2015-16, and they are having to make savings of £492 million in 2016-17.

I have a question for Mr Gray and the cabinet secretary. Are you seriously saying to the public that every one of those savings that health boards are having to make is an efficiency saving? Are they entirely efficiency savings?

10:15

Shona Robison: You will recognise that, as I said earlier, all the parties put forward their prospectus for health funding, and my party's commitment to provide £500 million above inflation was the highest of any party. That went in front of the public, who made their choice. The health service has now had an above-inflation uplift. Obviously, boards' funding varies, but every board has had an above-inflation uplift.

Efficiency savings have always been part of changing the way that services are delivered. Every penny of those efficiency savings is reinvested in the front line. We expect boards to ensure that they make efficiency savings in the right way to free up resources for the front line.

You are right about demand rising. That is why Audit Scotland's conclusion is that reform is required. Audit Scotland says that throwing more and more money at the NHS is not the key answer; the key answer is reform and doing things differently. We agree. Increasing levels of investment are not enough; we have to change the way that we do things, and we have to keep people out of hospital and treat more people in primary care and community services. I have not heard any alternative to the plan that we have proposed, and my plea is for people to get behind it.

Paul Gray: There are some things that we need to stop doing and which we want to stop doing. The plan is not simply about trying to make everything better and faster. I am sure that the chief medical officer would be happy to brief the committee on her approach to realistic medicine, which, if implemented effectively, will mean that certain procedures of limited value will be stopped. We will not do them any more because they are of limited value. That discussion needs to be had with the public, and clinicians are much better placed to have it than I am. The plan is not about simply saying that everything will continue as is but will be a bit better and faster.

We have made efficiency savings. For example, NHS Fife has an efficiency programme to achieve greater compliance with the agreed drug formulary, and getting 80 per cent compliance in the board area will produce a saving of £8 million. Glasgow health and social care partnership has done work on a community respiratory team to support patients with chronic obstructive pulmonary disease. That work has reduced in-patient admissions, reduced the length of stay for those who are admitted and led to more efficient use of medicines and devices at home.

I will not give a great long list because I am conscious of the time constraint. There are things that will stop, but they will stop because they do not provide value, because we have better techniques, because there are improved treatments or because better drugs are now on the market. In no way am I trying to suggest to the committee that everything will remain the same. As the cabinet secretary said, it cannot remain the same and deliver what the people of Scotland need.

Colin Smyth: The question was about all the efficiency savings. Are you telling the committee that, of the £492 million-worth of savings that health boards will have to make in 2016-17, not a single one will adversely affect patient care? Are you telling the committee that every penny of

those savings is an efficiency saving or a change in order to do things better, and that none of them is to do with balancing the books or will impact adversely on patient care?

Shona Robison: It is important that the books are balanced but it is also important that patients get a good service. In the changes that they make, we expect boards to improve services by delivering them differently. They can be delivered more efficiently—Paul Gray has just outlined a small number of examples of how that can happen. If we do not encourage and support boards to make those changes, nothing will change. We need to ensure that every penny and every pound is spent most efficiently. That is a prudent way to manage the health service's finances.

Colin Smyth: Nobody disagrees with that, cabinet secretary, but it did not answer the question. The reality is that, if we are going to take the public with us on transformational change, we have to be honest with them. It is not honest if we say to them that not a single penny of the savings that health boards are making will adversely impact on care. Staff and patients see that every day. Instead of simply dismissing funding matters as just efficiency savings and changes, why are we not honest with the public that the decisions are difficult and will impact adversely because there is not sufficient funding to meet demand? You cannot take the public with you unless you are honest that health boards will make cuts that will adversely impact on patient care.

Shona Robison: But all those efficiency savings are reinvested in services that patients want and need. Efficiency savings are there to help to drive reform and change and to be reinvested in the front line. It is about doing things better and differently. Inevitably, some of those decisions will be difficult because, as I said, change is difficult. We work with boards to ensure that the efficiency savings that they have identified will make those improvements. We do not just sit back and tell boards to go and do whatever they want—it is a managed process. We require boards to discuss with us the level of efficiency savings, what those savings are and, importantly, what change they will deliver.

Colin Smyth: You mentioned your manifesto commitments on funding. Where in the manifesto did you commit to reducing local government budgets by £450 million? Has that been a good thing or a bad thing for social care and preventative healthcare?

Shona Robison: The public made their choice based on the manifesto prospectus that each party put forward. We put forward a prospectus to increase health funding by £500 million more than inflation. The public made their choice and their decision—at the end of the day, that is what elections and democracy are about. We were very clear about our spending priorities. We have also transferred £250 million into social care, because we believe that it is important that we look at the whole system. Health and care are inextricably linked, and the £250 million for social care is delivering extra capacity in social care, which can get people out of hospital and keep them out. It is also delivering the living wage for 40,000 care workers, which I would hope the member would welcome.

Colin Smyth: I certainly welcome that, because I proposed it several years ago, but—

The Convener: I need to stop you there, Colin. We have run over time because we started a wee bit late, and three members of the committee still want in.

Ivan McKee (Glasgow Provan) (SNP): I want to clarify and dig a wee bit deeper into some of the numbers in the budget so that I understand them a wee bit better. People are throwing about comments about cuts to this and cuts to that. Is it true to say that in 2015-16 the budget was £12.2 billion and in 2016-17 it is £12.9 billion, which is an increase in cash terms of £700 million?

Shona Robison: That is correct.

Ivan McKee: Even taking into account inflation, the increase in real terms is 2.7 per cent.

Shona Robison: Correct.

Ivan McKee: So, overall, more money is going into the health service. There is twice as much extra money as you need to cover the rise in costs because of inflation. Those are the facts on what is going on.

The Audit Scotland report talks about £492 million in savings but, obviously, that is in the context of extra funds going in. Is it not therefore correct to identify that as a redirection of resources within the health service because, in effect, that £492 million is being moved to other areas of the health service, along with the extra £700 million that is going in on top? Is that a fair characterisation?

Shona Robison: That is correct. Without doing that, we would not be able to resource the shift in the balance in the investment in primary care and the changes that need to be made. We cannot do that just with new money alone; we also have to shift the existing resources, which is partly what the efficiency savings do.

Ivan McKee: Absolutely. I just wanted to make that clear, because people look at that figure and think that it is £492 million of cuts, but there is in fact a £700 million increase in cash terms. Clearly, the issue comes down to what you deliver for that,

but it is also true to say that there has been an increase in demand, with more GP visits, in-patient episodes and out-patient demand, plus the cost of drugs is going up. Therefore, in relation to what is being delivered for that money, which is the real measure of efficiency, is it true to say that we are getting more bang for our buck, if you like, in terms of the output from the health service?

Shona Robison: Far more people are being treated in the health service than ever before. Out-patient demand, in-patient demand and demand for GP services are increasing. That is the point that Audit Scotland makes—demand is growing and we have to manage that and ensure that we use the collective resources and all the skills in the NHS to get people to the right place. That is the programme of reform and transformation that is under way. So, as you say, although there are additional resources in the NHS, including a redirection of existing resources, the caveat is that demand is growing.

Ivan McKee: Okay. I have a final point. It is clear that in the national clinical strategy and through integration and so on, there is a direction. Health boards are coming forward with proposals that they state are aligned with that, but each of those proposals would need to be examined to understand whether it was actually aligned with the strategy or whether the health board was just putting it in that context, but there was no alignment with the strategy.

Shona Robison: Correct.

Ivan McKee: It is clear that everything that a health board comes forward with does not necessarily comply with the strategy just because the health board describes it in that way.

At the end of its report, Audit Scotland talks about New Zealand, where Canterbury has made the shift towards more integration and community spend. Have you looked at that in detail? Do you have any understanding of how that was done and what it delivered in real terms? Currently, it is very much about having an aspiration that we think will save us money; in theory, it should, but, as the report says, we do not have hard-and-fast numbers. Does the New Zealand experience give us any confidence about how much can be delivered by going down that road?

Shona Robison: We have looked at international experience, and we can draw some information from that, but every health service is unique. Therefore, the solution has to be a Scottish one. I am sure that there are lessons to be learned from elsewhere, but the plan and the strategies that we have are very much born out of the needs of the Scottish population and the type of systems that we have here.

Ivan McKee: Okay. Thanks.

Miles Briggs (Lothian) (Con): Good morning, cabinet secretary and Mr Gray.

An aspect of Audit Scotland's report that has not been touched on in the Parliament is to do with the estate. Repairs are needed to almost a third of all NHS buildings, there is a 50 per cent maintenance backlog and boards are now classifying maintenance requirements as "high risk" and "significant". What programme are you aware of to address the estate issue? Are we building up a future NHS buildings crisis?

On Ivan McKee's question, what do you think health inflation sits at?

Shona Robison: Again, we can write to the committee with the details of this but, from memory, a recent report showed that there had been an improvement in the amount of work that had been done on the most urgent parts of the estate. It is also important to note that there has been continuing massive capital investment in renewing the estate. We should look at not just the hospital building programme, but the investments in new health and care centres and primary care facilities. There is a lot of capital investment going into renewing the estate and making it fit for the future. I am certainly happy to write to the committee with more details on that.

Health service inflation is 3 per cent.

Paul Gray: Traditional pay and prices inflation varies from 1 per cent on pay to 10 per cent on drugs. Taken as an average across all the areas of expenditure, pay and prices inflation is between 2 and 3 per cent—it is probably closer to 3 per cent than 2 per cent.

We estimate that changes in demographics account for about 1 per cent per annum in costs. In other words, if the demographic trends continue, that will cost us another 1 per cent a year.

Shona Robison: The figure is circa 3 per cent.

Miles Briggs: I will come back on both points. What is concerning for me about the estate is that the report says that both NHS Lothian and NHS Tayside, which are in the most difficult financial positions, have fallen back in relation to their estate, and the number of buildings that are at high and significant risk has increased. We really have to be aware of that and the decisions that are taken by those boards.

A number of people who have given evidence to the committee have said that they see health inflation at 6 per cent. There seems to be a lot of discrepancy in budgeting in the health service, with people working with figures of between 1 and 3 per cent, from what has just been said.

Shona Robison: I cannot really account for what others say about inflation. We are saying that, from the work that has been done in the health department, those are the figures.

Miles Briggs: Should that be reviewed?

Shona Robison: The gross domestic product deflator is 1.8 per cent. That is a proxy for general inflation. Inflation in health is around 3 per cent, taking into account the other aspects that Paul Gray talked about. That is the basis of our calculations.

Ivan McKee: Just to be clear, the Audit Scotland report has a figure of 3.1 per cent. That is what Audit Scotland thinks it is.

Shona Robison: Given that we accept the Audit Scotland report, that is probably a good place to agree.

The Convener: I suggest that there should be some correspondence with the health boards. My health board certainly tells me that the figure sits at 6 per cent. It is clear that we have a problem if the NHS centrally is working to a figure that is different from the one that boards are working to. Some correspondence on that might be helpful.

I am sorry, but I will have to finish the discussion there. I thank the cabinet secretary very much. There will be a brief suspension. We will try to catch up on time in the next evidence session.

10:30

Meeting suspended.

10:32

On resuming—

Recruitment and Retention

The Convener: Item 2 is our final evidence-taking session on recruitment and retention in the health service. I welcome back Shona Robison, the Cabinet Secretary for Health and Sport. She is accompanied by two officials from the Scottish Government: Shirley Rogers, the director of health workforce and strategic change, and Fiona McQueen, the chief nursing officer. Welcome to the committee. I invite the cabinet secretary to make an opening statement.

Shona Robison: Thank you for the invitation to speak again to the committee. We are all aware that demand for health and social care services is changing, as is the way in which those services are delivered. In response, the Scottish Government has a programme of transformational change to take us towards the 2020 vision and beyond. However, we cannot deliver that without a sustainable workforce.

Our approach to delivering that workforce is described in "Everyone Matters—2020 Workforce Vision". In short, we need to ensure that the right people are available to deliver the right care in the right place at the right time.

Key to our ability to recruit and retain our staff is our attractiveness and inclusiveness as an employer. Through our work on the staff governance standard, NHS Scotland has made significant progress in recent years. We have worked closely with our staff-side partners and health board colleagues to develop high-quality and supportive policies and terms and conditions for our staff that also recognise the highest standards of equality and diversity and help us to deliver on our vision for NHS Scotland to be an exemplar employer. I was delighted that NHS Scotland's good work was recognised in practice when the Golden Jubilee national hospital was recently voted employer of the year at the 2016 awards.

Under this Government, staff numbers have increased by more than 11,000, which includes over 5 per cent more qualified nurses and midwives and over 25 per cent more doctors. We have a record number of consultants—the number has gone up by 43 per cent during the Government's term. However, we are not complacent and we recognise that challenges remain. We need to improve the long-term sustainability of our workforce, particularly in remote and rural settings.

We are growing our medical workforce. In addition to increasing specialty training places by

124 in the past three years, we have increased undergraduate medical school places by 50 from this year, and those places are focusing on widening-access criteria. The Scottish graduate entry medical programme—ScotGEM—will add a further 40 places from 2018 and will focus on general practice and rurality.

We signalled our intention that the ScotGEM programme will have an element of bonding, by which I mean an arrangement whereby, in return for the reimbursement of the cost of their education, an individual commits to a period of employment in the NHS. I am aware of the evidence that was given to the committee last week and I realise that there is a range of views on such arrangements. We are developing our policy on bonding and I welcome the opportunity to discuss it further with the committee and the wider stakeholder community.

We are committed to developing a national and regional workforce plan by spring next year. The plan will seek to address capacity issues consistently in the right places and at the right levels in our workforce to help to deliver the transformation agenda that is envisaged in our national clinical strategy. We recognise the need to strengthen workforce planning to ensure that the workforce is able to deploy and manage its huge range of knowledge and skills to best effect, not just by having the right numbers but by ensuring that people are in the right places at the right times.

I recognise that those initiatives will not produce instant results. We are therefore also looking at actions that will address the challenges that we face now. A number of key actions are under way to reduce the use of costly agency staff, including the use of a staff bank system and a long-standing framework contract. We accept that we need to do more and, with NHS National Services Scotland, we have launched a nationally co-ordinated programme to ensure the effective management of all temporary staffing and help boards to reduce the reliance on agency staff.

We are well aware that some parts of the country, including rural areas, have particular challenges in relation to recruitment. We have invested £2 million in GP recruitment and retention measures, which include the Scottish rural collaborative and support for deep-end practices. We are also working with universities to increase meaningful exposure to remote and rural placements at undergraduate level. Additionally, we are encouraging those who have trained and worked in NHS Scotland to return and work here in the health service.

Finally, I have to highlight that, in the context of a highly competitive international recruitment and retention market, there is a risk that because of Brexit we will lose many valued individuals if we cannot offer reassurances on free movement and future career opportunities.

I am committed to building a sustainable health and social care workforce for the future and I welcome the opportunity to discuss the issues further.

The Convener: Thank you. We are extremely short of time, so I would appreciate brief questions and answers from people.

Alex Cole-Hamilton: Last week, we heard evidence from people in the midwifery profession and the nursing profession that, five or six years ago, the Scottish Government cut back training in the midwifery profession in a move that equated to a loss of roughly more than half the training places. They also told us that they are talking about a crisis in recruitment because of retirement.

Workforce planning in the NHS focuses on a five-year period. Will the workforce plan that you are talking about for next year take account of the Audit Scotland report that—rightly—points out that we need to stare much further into the future, in the recognition that it takes up to seven to 10 years to train some primary care professionals? Will the plan that you bring forward reflect that?

Shona Robison: Fiona McQueen can say more but, over the past three years, we have increased nursing and midwifery numbers. We have also increased the numbers of those who are in advanced training, and we have increased the number of advanced nurse practitioner posts by 500. We are aware that that workforce is critical not only in our hospital sector but in our primary care sector. We have been working closely with NHS Education for Scotland to develop opportunities for the advanced nursing practice career route, because we know that, whether in emergency medicine or primary care, the roles of advanced nurses will be critical in delivering the new models.

Fiona McQueen (Scottish Government): That is absolutely the case. The person from the RCM who spoke to the committee last week recognised that, when undergraduate numbers were reduced, there were hundreds of unemployed midwives and nurses. We had 800 nurses on return-to-practice schemes and we had nurses and midwives who were qualifying and unable to get jobs.

We have a planning process that looks at retiral rates, and people now have the choice of retiring from 55 onwards. There is a challenge, because overproduction is not helpful either, as it stops good people coming into the profession.

Over the past three years, we have increased the numbers. The number of midwives in training has been increasing.

The Convener: Who signs off the annual intake?

Fiona McQueen: There is a process. Ultimately, the cabinet secretary agrees to the position.

The Convener: That is fine.

Shona Robison: There is a process of negotiation in the professions.

Fiona McQueen: The trade unions are involved and the care home sector is now involved.

Clare Haughey (Rutherglen) (SNP): I would like to get my head round some of the vacancy rates. The figures for June that ISD published put the vacancy rate for nursing and midwifery at 4.2 per cent and for other AHPs at 4.4 per cent. What do you see as a usual percentage for vacancies? We will not have every post filled all the time.

Shona Robison: One of the challenges is that the more posts we create, the higher the vacancy rates are, particularly in areas where recruitment is harder. The ISD figures are national, but vacancy rates vary across the boards.

Fiona McQueen: Recruitment takes time. If we look at industry norms, 4 per cent is a moderate figure. The position depends on the post. If the post is that of a staff nurse who delivers care all the time, that person needs to be replaced right away, and the situation is similar for our support workers. In that case, it is easier to have a recruitment line. Along with workforce colleagues, the nursing and workforce directors on boards look at how to efficiently fill posts because, although someone might give four weeks' notice, the recruitment process takes longer than that. A number of boards anticipate situations by looking at their turnover and bringing people in so that there is almost no vacancy for the post that is being left.

More specialist posts take time to recruit for. Even if there is no difficulty in recruiting, if someone gives one month's notice and people have to be pulled in, the recruitment process will take longer than that month, so there will be a period of vacancy.

The figures vary depending on the area that a person is in and how long they are leaving their post for, but 4 per cent does not seem unreasonable. Vacancies that last for more than three months might be indicators of where it is trickier to recruit. Shirley Rogers can add to that.

Shirley Rogers (Scottish Government): It is difficult to give a global answer. Some specialties are harder to recruit for. The committee might find it helpful to understand more about the workforce planning that takes place. I recognise the time constraints, convener, but I would like to say a few words on that.

Mr Cameron asked earlier about the prospective nature of workforce planning. Over the past couple of years, we have put in place arrangements that allow us to see the existing trained workforce and the supply, through specialty doctors, that is coming through the training process. We can see the consultant workforce as we have it and all the people who are emerging from medical school, who we can track through training. That is the case across all the 56 major specialties in the health service.

Those arrangements enable us to make intelligent decisions that are based on projections of retirement ages, for example. The committee has heard evidence about the impact of UK pension changes. The arrangements allow us to see what would happen if the consultant workforce decided to retire a bit earlier, stay on a bit longer or whatever it is.

The approach over the past couple of years has used the six-step workforce planning methodology, which is an international industry standard that does not pertain just to the health service. It is used by a number of big employers around the globe to look at short, medium and long-term recruitment needs and at how to nuance them depending on the circumstances and the individual choices that people make.

The methodology has been shared across the health service and is now a requirement for how every board in Scotland does workforce planning. That is a relatively recent development. Perhaps more important in the space of health and social care integration is that we are busy sharing the methodology with colleagues in local authorities to make sure that they use a similar methodology. Indeed, we have invited any other employer that is operating in that space to use a similar methodology. That should enable us to address as best we can the issues that exist now and, more important, to deal with the medium and longer term.

I thought that it might be helpful to give the committee that context on the workforce planning methodology.

10:45

Clare Haughey: I will come back on something that is a bit more specific about nurse retention. I declare an interest because I am a registrant with the Nursing and Midwifery Council and I am going through the revalidation process.

My question is about registration and revalidation. Has any work been done on how many nurses and midwives are leaving the

profession because of the revalidation process, which is quite complex, and on nurses and midwives who fall off the register because of late payment of their registration fees and the excessive time that it takes the NMC to get people back on to the register—up to three months—which leaves those nurses and midwives without a source of income? They are often women who work part time and are sole parents. I am keen to hear what the Scottish Government is doing to support that part of the workforce.

Fiona McQueen: I am happy to answer and equally happy to give you granular information on a month-by-month basis about revalidation and people's registration lapsing or not. We have found that there is little difference in the number of people who are remaining on the register. September was going to be our crunch month, as we had a lot of registrants who qualified in September and revalidation is three yearly from then.

We have found that, in the care home sector and across the NHS in Scotland, there has been little difference since revalidation came in; we have watched that closely. We have invested money over the past two years to support each board. We gave boards resource to support practitioners with revalidation and we worked closely with the NMC to get the statistics and data on that.

Other committee members might not know that nurses have a system of submitting for revalidation every three years but we have to pay an annual fee. Until quite recently, if someone missed paying the annual fee by a few days, that did not matter, but now the NMC says that re-registering will take between two and eight weeks. We continue to encourage the NMC to be as quick as it can in its processes, as we fully recognise the financial challenge that registrants have and the issue of care delivery. Someone who has not paid cannot deliver care as a registered nurse during that time.

We are continuing to work closely with the NMC on the issue and we are looking at ways that we can flag to boards for them to remind nurses that they have an annual fee to pay. The NMC reminds people quite regularly about what needs to be done. Any time that we hear of anyone having that struggle, we direct them to someone in their board who can help them, to make sure that they are paying.

The NMC has introduced a way to spread fees by paying instalments by direct debit rather than paying £120 a year all at once, so the NMC is doing its best to support registrants to maintain their registration.

Richard Lyle: I believe that it takes on average five to seven years to train a doctor. I was surprised when I last met the BMA that once a doctor has trained they can just go away, anywhere in the world. The cabinet secretary said something earlier about bonding, which is a new word to me. Why do we not tie doctors down to a contract that says that if they trained in Scotland, they should live and work in Scotland? Should they not pay back to Scotland before they leave? I hate using the word "leave".

Shona Robison: Shirley Rogers will say a bit more about this in a moment, but obviously we want people to remain here and train and work here. A lot of the evidence shows that if they have had a good training experience and good experiences in their placements that is a big encourager for doctors to want to stay here in Scotland. There is an international market and we have looked at how we can encourage, with financial incentives or in other ways, the keeping of people here in the NHS.

The graduate programme lends itself well to bonding because it leads to a second degree and, therefore, the fees are not automatically paid. That means that there is an opportunity to offer any payment of fees through the graduate programme with a commitment to the NHS in Scotland. That would be more challenging to do in the undergraduate programme. It is not that it is not being explored and we will keep an open mind on what more we can do.

From a widening access point of view, you will be interested to know that, because we felt that it was important that medical students were drawn from a wider socioeconomic base, we linked to the widening access criteria the 50 new places from this year that we have agreed with the medical schools. The more that we draw people from a wider variety of backgrounds, the greater the chance we will have of them staying in Scotland to work in the NHS.

Shirley Rogers: Scotland has five of the most highly regarded medical schools in the world. It attracts and draws candidates from all over the world. That is one of the things that it should be proud of. Scotland has a long history of medical academia and medical research that is very attractive in an international marketplace. We operate in an international marketplace for medics and it is right that we do that. We are extremely innovative but we are not the only innovative place.

However, there is evidence that strongly suggests that Scotland-domiciled students who attend Scottish medical schools are more likely to practise in Scotland immediately or come back to practise in Scotland—they may go somewhere else to gain experience and then return to

Scotland later. We are trying to create a space in which NHS Scotland is internationally recognised as an attractive place to practise medicine. An enormous amount of work is being done to improve working lives throughout the NHS and specifically for junior doctors, for example. That recognition is starting to accrue.

As the cabinet secretary said, we have focused a particular endeavour on the introduction of a first for Scotland: it is the first time that we will have a graduate medical school. We have done that because we recognise that, generally speaking, people who are doing second degrees are a little bit older, are a little bit more settled in the environment in which they want to live and have perhaps already made some domestic decisions and life choices that would more readily site them in Scotland. Therefore, if we can support those individuals to make those choices, it seems that the options for us to be able to have some payback for that investment are before us.

As the cabinet secretary indicated, we are in the foothills of that consideration. Committee members may be aware that that model has been used in the military for a number of years and is used in some parts of the world. There are a number of models, but we are ensuring that we have a balance of people who really want to work in Scotland and to make their medical careers and their lives here. We will be able to do that.

Richard Lyle: How much is the funding or bonding on offer?

Shona Robison: We have not reached that stage yet. I guess that we would be looking at an arrangement such as, if we paid a year's fees, we would expect a year's commitment to the NHS. That would be an obvious way of doing it, but we need to work through the detail before the programme starts.

Richard Lyle: So if somebody commits to stay five years, we will pay their five years' fees.

Shona Robison: That is an option. We need to work through the detail.

Maree Todd (Highlands and Islands) (SNP): As a representative for the Highlands and Islands, I am keen to ask about rural recruitment. We have heard time and again that people from the Highlands and Islands are keen to get back and I know that from personal experience. Will the widening access scheme cover people who grow up in rural areas, who might face challenges in getting the right qualifications to enter medical school because of the limited options that are available at the high schools in rural areas in the Highlands and Islands?

The Convener: We have three further members who wish to ask questions and we are short of time, so I ask you to be brief, please, cabinet secretary.

Shona Robison: The ScotGEM—Scottish graduate entry medicine—system will partner with NHS Highland on rural placements and rural opportunities, plus there are existing programmes through the Scottish rural medicine collaborative to encourage and retain staff who work in rural areas. The graduate scheme has the ability to give people a very positive experience of working in a rural area and it will have a bias towards general practice, too.

Maree Todd: I meant specifically with regard to getting access to medical school.

Shirley Rogers: It is one of a number of things that we hope will do that. We are working with schools to look at the triangulation of qualification, medical school applicant and the chances that there are for study opportunities. We are working with education colleagues to ensure that the necessary curriculum is available—that would probably be the biggest win, if we can achieve that. There is no doubt that the postgraduate entry requirements lend themselves better to students who have not been able to study, for example, higher chemistry in rural parts of Scotland.

In her opening remarks, the cabinet secretary mentioned rural bursaries, which are terribly advantageous for recruiting in rural parts of Scotland. It is a totality of things as opposed to just a thing, but that totality ought to achieve the objective. Again, there is very strong evidence that people from those communities who can practise in those communities will stay in those communities.

Maree Todd: Absolutely. To broaden the question beyond medical staff, we have heard from all the professions—particularly midwives, nurses and allied health professionals—that they are struggling to offer opportunities for work experience in rural areas and that there might be additional costs for people who want to work in rural areas during their training period, either as undergraduates or as postgraduate students. Will the Government do anything to tackle that? I welcome the strategies that you have already put in place to tackle the issues.

Shona Robison: We provide 300 pre-registration nursing places through the University of Stirling and the University of the Highlands and Islands, and a further 60 nursing students from seven boards that cover remote and rural areas study a pre-registration nursing programme through the Open University. Those are good options for people who are from the Highlands and Islands, and the Western Isles has a particularly good programme. It is about home-growing our

workforce from school right through to qualification.

Fiona McQueen: We are also reviewing the financial support that we give to other undergraduates, such as AHP undergraduates—nurses already get travel and accommodation expenses when they are on placement. We are looking at more rural placements for our undergraduates.

Ivan McKee: I want to comment quickly on the workforce planning tool. I was glad to hear the comment that Shirley Rogers made because, in previous evidence sessions, people have told us that workforce planning is difficult—to the point of being too difficult—and that we should not expect them to deliver anything coherent on that. I am glad to hear that you are on top of that.

I have done workforce planning in the past and my experience is that it is 90 per cent science. It is about getting the right variables, understanding how those are trending and making adjustments based on that. More importantly, although you will get it wrong, it is about knowing what to go back and look at when that happens. You can then understand whether the decisions that you made were coherent and based on the data. Would it be possible to have a wee look at the planning? I would be interested to see what the tool is capable of doing, although I do not know whether other members would be interested.

Shirley Rogers: I am happy to share the six-step methodology with the committee.

Ivan McKee: Brilliant. Thanks very much.

Alison Johnstone: What action has been taken to ensure that those working in the professions have access to a suitable level of on-going professional development? Jill Vickerman said that that issue is not making medicine as attractive as it might be in Scotland.

Also, what specific action is being undertaken to recruit in our deep-end practices?

Shona Robison: In part, it is about ensuring that people have the time—and that backfilling is in place—to be able to take on professional development opportunities. We also need to ensure that there is equality of access to those opportunities. There are issues in some areas where that is more difficult but, without a doubt, CPD is hugely important for career development and for opportunities.

11:00

Shirley Rogers: I am the individual who is leading the work to develop the transformational strategic change plan, which we have mentioned a number of times in the meeting. We recognise in that plan that education and reskilling, upskilling and maintaining skills are a fundamental part of transformation. Opportunities for people to be able to do that—we have dealt with the testing of new models of care—are critical to that work. We are configuring to do that in a range of ways.

We always talk about doctors and nurses, so I will give an example that goes a little bit beyond their remit. A quiet success of the past couple of years has been the development of the educational framework for healthcare support workers. That extends way beyond health into all the social care provision and gives an educationally based career framework that allows people to join at a relatively modest level of skill, to use the framework to develop their skills and, of course, to enhance their careers. We are taking that approach and methodology throughout.

The cabinet secretary mentioned deep-end practices. We are exploring the benefits of a rural bursary, and we are starting to give consideration to whether a bursary around deep-end practice would be effective.

Shona Robison: We have agreed with the BMA a full review of all aspects of GP pay and expenses. That will take place next year and will inform options from 2018. The Scottish allocation formula will be part of those discussions.

I have said before that we need to get that work right. Our support for deep-end practices is important, but we need to look beyond that and at how we ensure that GPs working in more deprived areas get the support that they require. We also have, for example, the 250 link workers to support practices in deprived areas. The issue of support is very much a focus of our discussions as we take forward the new contract.

Miles Briggs: Between 2006 and 2013, the number of student nurse placements was cut by a quarter. Was that the wrong decision? The number of places for Scotland-domiciled students at Scottish universities is capped. What impact is that having, especially given that just 52 per cent of students going to our medical schools are Scotland-domiciled students, which is a historical low?

Shona Robison: Fiona McQueen can come in on the nursing numbers, although she answered in some detail the point about the oversupply and the need to adjust the workforce requirements. Requirements change over time, and it is quite difficult to land that 100 per cent accurately.

Over the past three years, we have seen an increase in the number of undergraduate places. That will filter through into the workforce. It is important to have advanced nurse training, as well as undergraduate training.

It might be of interest to the committee to look at the overall numbers of medical students in Scotland. As Shirley Rogers said, we have five medical schools. That is a high number for a country with a population of 5.3 million. The total number of medical students across the UK is just over 40,000. If we were to take a population share of that number, Scotland's figure would be just short of 3,500. However, we have more than 1,400 medical students above our share. In essence, we are providing far more places and producing far more medical graduates than our population share. You have to see the percentage of Scotland-domiciled students in that context. If we are to sustain five medical schools—as we want to—they must be able to draw their undergraduates from a wider source, whether that is from the rest of the UK or internationally. As I say, we produce far more medical graduates than our population share or any other part of the UK per head of population. That is a good thing. Our five medical schools are internationally recognised, but in order to sustain them we have to draw from a wider pool than just Scotland.

Miles Briggs: Is that a financing issue, in that international students can be charged up to £30,000 to study at Scottish universities, whereas Scotland-domiciled students are not?

Shona Robison: We discuss the issue with universities and the Scottish Further and Higher Education Funding Council. Our medical schools have always drawn people from a wide variety of backgrounds and places, which I suppose is part of the richness of those schools. A number of international students study medicine in Scotland, as well as a large number of students from the rest of the UK. We want them to stay and work here in Scotland and we encourage them to do so through the mechanisms that Shirley Rogers outlined.

Do you want to add anything, Shirley?

Shirley Rogers: No—that covers it. The reality is that universities survive by having a mixture of students—Scotland-domiciled students, those from international backgrounds and those from the rest of the UK. We have a close relationship with the Scottish Board for Academic Medicine, which represents the medical schools in Scotland, and I meet it regularly.

To return to Ms Todd's question, the medical schools are very keen to work collaboratively to provide placement opportunities in, for example, remote and rural locations or deep-end practices. Those relationships are very good. As the workforce director for the NHS in Scotland, I endeavour to have a sustainable world-class workforce.

Shona Robison: Within that, we of course want more Scotland-based students, which is why we are widening the number of undergraduate medical places even further, by 50. That will be 250 more places over a five-year period, plus the places in the graduate medical school. It is not that we do not recognise the need to expand the number of Scotland-based students, but it is important—

Miles Briggs: But the figure for Scotland-domiciled students going to the universities is capped. My question, which has not really been answered, is: what impact is that having?

Shirley Rogers: I was going to come back to that question, because I do not recognise the point that you are making about the cap.

Miles Briggs: When this Parliament was reconvened, 64 per cent of those going to medical schools were Scots, but the figure is now down to 52 per cent because of the cap.

Shona Robison: Yes, but if you look at the overall numbers, we produce a huge number of medical graduates beyond our population share. If we only produced the number of medical graduates as a percentage of the 40,000 across the UK—

Miles Briggs: But Ms Rogers has said that it is important that people who are domiciled in a country can study there, and we are reducing that number in Scotland. If we had more Scotland-domiciled people studying, that would surely help to tackle the shortage. That is where the cap is not helping.

Shona Robison: We have just increased the number of places by 50, and we have linked those places to widening access, which means that people from poorer backgrounds will get into medicine who would not previously have done so. There are 250 more medical places over the course of five years. Plus, we think that the graduate school will draw mainly from Scotland-domiciled students because, as Shirley Rogers said, the students in that school will be a bit older and more settled. Therefore, we are expanding the number of Scotland-domiciled students, and that is in the context of a large pool of medical places in Scotland, which is sustained in part by drawing people from elsewhere.

Miles Briggs: Okay—I am not getting very far with this.

The Convener: Thank you very much.

I suspend the meeting briefly to allow the panels to change.

11:08

Meeting suspended.

11:11

On resuming—

Mental Health

The Convener: The third item on our agenda is the first evidence session in our mental health inquiry. In this session, we will look at child and adolescent mental health services. I welcome to the committee Rachel Stewart, who is the senior public affairs officer at the Scottish Association for Mental Health; Sophie Pilgrim, who is the director of Kindred Advocacy and a representative of the Scottish children's services coalition; and Michael Gowan, who is a member of the Scottish Youth Parliament.

Before I invite questions from my colleagues, could one or all of you—it would probably be better if one of you did it, given the time constraints—explain tiered intervention in child and adolescent mental health services?

Rachel Stewart (Scottish Association for Mental Health): I can do that. Child and adolescent mental health services are set up in four tiers; tier 1 is for the least severe problems and tier 4 is for the most severe. Tier 1 is identification level, which is when a child would first seek help from universal services—a teacher, a general practitioner or someone else in universal services. It is the first port of call. Tier 2 is community-based CAMH specialist services, which involve primary mental health workers. Tier 3 is a bit more specialist and is where the access target—according to which children and young people should be seen within 18 weeks of referral to CAMHS support—starts to be applied. Tier 3 involves support for children with more severe, complex and persistent conditions. Tier 4 is specialist in-patient CAMHS, when young people need to be treated in hospital for a time.

The Convener: My limited experience of the issue when I was a teacher was that because of resource pressures quite significant pressure was put on support for learning staff and the like not to put children on individual education plans or to make referrals. Is that your experience? Have you found anecdotal evidence of that?

Rachel Stewart: We have found anecdotal evidence of the existence of a mixed picture across Scotland. Some places have quite good links between education and CAMHS in the health service, but there are other places where young people whom we surveyed and spoke to say that their guidance teacher did not know about CAMHS, and where the line of communication and the awareness link do not seem to be as good as they could be.

11:15

As to whether universal services are being told not to refer young people because of resource pressures, we would need a bit more evaluation of what is happening across the board to enable us to say whether that is the case. That is why SAMH has been calling for a wider review of the whole CAMH service and the four-tier system. The information that we have is about the access point, which is at tier 3, and onwards, but we do not know how many young people are seeking help before that point and being turned away or told that they might grow out of what they are experiencing and should just rest easy because it will pass.

We have been calling for a wider review so that we can explore the situation. As we are on the cusp of a new 10-year mental health strategy and a new 10-year child and adolescent health strategy, we think that consideration should be given to placing wider focus on the access points and on how well professionals are equipped to deal with people who ask for help.

The Convener: Has statistical analysis been carried out of how many young people are at each of the tiers? Over time, have the numbers gone down or up, or are they fairly consistent?

Rachel Stewart: The number of young people being referred to tier 3 services has been going up. There has also been a rise in the number of young people who, having been referred to tier 3 CAMH services, have not been deemed unwell enough to require that level of support. However, there has been no statistical analysis of the number of young people who seek support at tier 1—the universal level—or tier 2. Those numbers are not measured in the same way because there is no target attached to access points in those earlier stages of CAMHS support.

The Convener: That is very helpful. Thank you.

Alex Cole-Hamilton: Good morning, panel. It is well known by the parliamentarians and the stakeholders at today's meeting that, in addressing the significant difficulty that we have with delay in the CAMHS set-up, we are not in any way belittling the work of CAMHS workers.

The problem can be measured in a number of ways. For example, we do not have any tier 4 beds north of Dundee, and those that are ostensibly available are not always available because there are no staff to man them. In some parts of the country, children have to wait for up to two years—a considerable part of their young lives—for an initial appointment. In my constituency, I had a situation in which a child was struggling at school. An educational psychologist referred her to CAMHS in the belief that she might have undiagnosed autistic spectrum disorder. She

was seen for initial triage comparatively quickly—within a couple of months. The family received the devastating news that their daughter was on the autistic spectrum, but she had to wait another year for a formal diagnosis. In that time, she missed out on any state support that she would have been afforded if she had had a diagnosis.

I invite the panel to reflect on that situation. What do you think needs to change? Is money or investment needed, or do we need a change in policy direction? Are all those things required?

Sophie Pilgrim (Kindred Advocacy): I am director of an organisation that supports about 1,000 families every year. A very high proportion of the children have neurodevelopmental—mainly autistic spectrum—disorders.

Regarding the situation that Alex Cole-Hamilton talked about, our experience is that schools often do not recognise quite clear signs of autistic spectrum disorder early on, and children get picked up only when things start to go wrong. As he said, the problem then is that there can be an extremely long time before formal diagnosis.

Looking after a child with autism is completely different from looking after a child without autism. There is a huge range of autistic spectrum disorder, but there are certain things that people with autism have in common, one of which is a need for structure. They probably also have a need for a less stimulating environment. Until a diagnosis is obtained, it is not possible to put in place the necessary support.

In working with children who have a very high level of additional support needs, one of the issues that we see is that there is, as Alex-Cole Hamilton mentioned, a lack of the high-level tier 4 services. In Scotland, we have no in-patient services for children with learning disability, no specialist in-patient services for children with autism and no forensic in-patient services. The Scottish Government and Mental Welfare Commission for Scotland are about to publish a report, which will recommend the provision of central belt in-patient care for those children.

Currently, the impact of children who have extreme needs is that other services are distorted. There are children who experience high levels of distress and community services are drawn into emergencies, which take up their time. Anyone who is in regular contact with CAMHS psychiatrists knows that they are unable to get on with their regular duties because their time is taken up by emergency acute care of children who need short periods in hospital. That is a big issue. We need the top level of support for children so that we can free up time for CAMHS to diagnose more quickly.

Miles Briggs: I congratulate the Scottish Youth Parliament on its survey and its report, "Our generation's epidemic: Young people's awareness and experience of mental health information, support, and services", which is helpful in its consideration of what is a huge problem for our country.

I am interested in early intervention and prevention. We get a lot of mixed messages about what improvements are needed and how the Scottish Government's new strategy should be shaped. What interventions or additional information for young people would make the most difference? How should such approaches be rolled out?

Michael Gowan (Scottish Youth Parliament): Thanks for the plug.

A key issue that was identified, which links to what the convener said, is that resources in schools are stretched too thinly. For example, one respondent to our survey said;

> "Teachers are really stretched too thin, and there aren't enough resources."

Another said:

> "25 students in one class is way too many for a class to be able to give one-to-one support. It should be like 10 or 15."

Young people asked how front-line practitioners could be expected to detect problems and manage them.

Training is another issue. How many teachers in more rural areas, for example, can do continuous professional development when there are staff-retention problems and schools cannot afford to let staff out often for CPD?

Only 24 per cent of the young people who responded to our survey said that they would be comfortable talking to a teacher. If only one in four pupils in a classroom is willing to talk to the person whom they see every day, that is a barrier to getting potentially quite vulnerable and underconfident young people to open up about problems, so that they can be caught early. We perhaps need to look at how we build bridges between young people and front-line practitioners.

Rachel Stewart: I endorse everything that Michael Gowan said. There have been pilot projects in which mental health and wellbeing have been promoted in schools. The "See me" pilots have had an impact on the whole school, in that young people have felt much more able to ask for help, and teachers who have been through Scottish mental health first aid have been able to respond much more appropriately. Teachers often feel very stressed, and teaching has a high sickness absence rate, so such training might help to protect teachers, too.

Other pilots, for example in Peebles high school, have linked with third sector organisations in the community including the Samaritans and Penumbra to raise awareness. That has made it easier to signpost young people to support.

Health and wellbeing is one of the three crucial elements in curriculum for excellence, but children and young people have been telling us that, in relation to mental health, the only thing that they ever hear about is how to deal with exam stress, and not how to be less stressed in general. If health and wellbeing were to be included in inspection of schools and there was more curriculum guidance about mental health, that would set a good tone.

Michael Gowan's point about continuing professional development and rural challenges was very well made. One of my colleagues in SAMH does an hour a term on mental health for some of the teacher training colleges. That is not really enough for the fourth-year students, so more such training could be considered.

Sophie Pilgrim: There are a lot of positive developments in how we support children who are on the autistic spectrum. Those developments can make a huge difference at virtually no cost, through spreading ideas about intensive behavioural support for families. We have two services in Scotland, both in NHS Lothian, that provide positive behavioural support to families. That is also being promoted within adult care for people with learning disability and autism. That can mean that we prevent the much higher cost of in-patient care.

Clare Haughey: Thank you to the panel for coming along this morning. I am sure that we are going to find out some really valuable information from you.

I was interested in a point that Sophie Pilgrim made about in-patient beds and the development of in-patient services. The focus of health at the moment is on developing community services as opposed to reprovisioning and in-patient services. I am aware that there is already a children's in-patient unit in the Royal hospital for children in Glasgow. Do you have any comment to make on use of the beds there? Has it been considered that some bed time there might be used for more specialist areas of child and adolescent mental health services?

Sophie Pilgrim: Provision at that hospital has a very good reputation, but it is to support children who are under 12 years old. It is predominantly in the teenage years that children and young people experience mental health issues. At present we have across Scotland three in-patient units for adolescents. The problem is that provision is not suited to children with learning disability or autism.

Clare Haughey: When we are talking about children, what age are we talking about? I am maybe confusing children with adolescents.

Sophie Pilgrim: We do not have provision that is specific to learning disability and autism for any child or young person under the age of 18. The Royal hospital for children in Glasgow has some expertise in that area. According to records, over the past five years about 85 children—that is probably an underestimate—have either had to be accommodated in adult wards or sent down south. It is not the case that they are being treated in the community: they are in-patients but they are very inappropriately treated and as a result end up being in hospital for a long time at great cost.

We have seen examples of children or young people in the three generic young people's units whose mental health has deteriorated dramatically. If they are transferred to a unit that is appropriate and has appropriate autism understanding and environment, they begin a process of recovery literally within days. Children who are sent down south can—after a very long time—be returned to the community support services, but sending them south to provision is really detrimental to their health and comes at great cost.

Clare Haughey: Just for clarification so that I have got it right in my own head, are you talking about adolescents, as opposed to children, when you are talking about children with specific disorders and illnesses?

Sophie Pilgrim: I am talking about children over 12. There is very little incidence of extreme need for in-patient care in the under-12s. At present we have national provision in Glasgow, which has a very high level of expertise and is well regarded.

Clare Haughey: You are saying that sometimes adolescents are admitted but the environment is not suitable, so is the problem the level of training of current in-patient staff in the adolescent mental health units?

11:30

Sophie Pilgrim: That is right. There is a difference between provision that is suited to children with autism and provision for children who have severe mental health issues who require in-patient care—for example, children who are bipolar, who have eating disorders or who have extreme anxiety and depression and who self-harm. Those children require the three services that we have in Scotland. However, for children with autism, we need a very highly structured environment, and we need specialist psychiatrists and CAMHS teams.

We have a very high level of specialist knowledge in Scotland. An advantage of the proposed service would be that the expertise, experience and support of the professionals would be disseminated to the health board and the community CAMHS teams, which would mean that we would be trying to prevent as much as possible the need for in-patient care. Obviously, in-patient care is very distressing and it is the last thing that we want, but we need it for all sectors of the community. At present, we have in-patient care for all sectors of the community apart from for children with learning disability. The Scottish Government has cited that as discrimination against those children.

The Convener: To be absolutely clear, we currently have no in-patient provision for children and adolescents between 12 and 18 with learning disabilities who require that level of care.

Sophie Pilgrim: Another way of putting it is that we have no secure in-patient psychiatric care for children. The children who require secure care are those with such extreme challenging behaviour that they are an extreme danger to themselves or to the public. That is a very small group of children. We need to be able to say that in Scotland we can care for any child and that no child needs to be sent away because their psychiatric needs are such that they cannot be cared for here. That group includes children with a forensic background of psychiatric need, children who have extreme challenging behaviour generally because they have autism, and children who have impaired understanding so that they have learning disabilities. It is for that very small extreme group.

The Convener: Thank you—that is helpful.

Miles Briggs: I want to pick up on Clare Haughey's point. Yesterday, I visited the Edinburgh crisis centre, which is run by Penumbra. It can take referrals only of people who are over 18, yet it could be quite an appropriate service for those between 16 and 18, and it has capacity for that. Does the panel agree that it might be appropriate to think about those who are over 16 rather than those who are over 18? With younger young people—or children—would it be more appropriate to have an intensive home nurse service to provide support so that those young people are not taken out of their homes and communities?

Rachel Stewart: In short, issues around self-harm in young people are not well catered for. We know from the Scottish health survey that there have been higher rates of detection of self-harm recently, especially among young women. We are calling for professionals who interact with young people, such as GPs, teachers and youth workers, to receive training so that they can respond appropriately if they discover that a young person is trying to cope with their mental health problems by self-harming, or if a young person approaches them to say that. Given the sensitivities of that and how unwell that young person might be, it has to be done in a certain way, which is why we call for training.

We know that the onset of mental health problems in adolescence tends to be at around 14. We can see from the research that young people's self-esteem and confidence often take a dip from 14 or 15 onwards, so having much earlier access to treatment and support would be appropriate and desirable.

There should absolutely be an at-home nurse service where that is possible. The Mental Welfare Commission for Scotland published its young person monitoring report a few weeks ago. That report showed that there has been a decrease in the number of young people who have been held and supported on adult wards in the past year from 207 to 135. That is still too high a number for those very unwell young people, but the MWCS attributed some of the decrease to an increase in the number of beds in Dundee and the more wraparound, multidisciplinary support in the community. That is to be welcomed and it would be good to see more of it.

Sophie Pilgrim: Children need in-patient care for acute treatment partly because, in some circumstances, their behaviour is extreme. For example, the other siblings might be at risk. Sometimes the children do not sleep, they are violent or their behaviour is extremely antisocial. The family breaks down under those circumstances because it is intolerable. In addition to the extremity of behaviour, it is also sometimes necessary to take the young person out of that environment and into a clinical environment so that they can be assessed. Generally, it takes three months to assess what disorders are going on so that they can be treated appropriately.

Michael Gowan: One of the points that came out of our research is that many young people and adolescents think that a transition service between the age of 16 or 18 up to about 24 would be beneficial. Therefore, rather than simply lowering the bar to 16, it might be worth creating a bespoke service in the NHS that focuses on tailoring treatment for them during that transition period and then trying to get third sector interfaces working with IJBs so that there is a linked-up approach where that is merited.

Alison Johnstone: For clarification, does Sophie Pilgrim believe that young people with neurodevelopmental disorders are best diagnosed and treated within the framework that exists in CAMHS or is she looking for something else?

Sophie Pilgrim: They have to be, really, because it has to be done within a consistent framework. It is a medical diagnosis. The problem is people not identifying disorders when the signs are evident and the fact that, as others have said, when young people are referred, diagnosis takes a long time.

Alison Johnstone: Several studies have indicated that adolescent girls in Scotland particularly suffer from poor mental health. I ask Michael Gowan and Rachel Stewart why that might be the case and what we are doing to tackle it.

Michael Gowan: Part of our research was about how some young girls felt that they were not taken seriously about poor mental health. If a young girl says that she feels depressed, the response might be, “Are you on your period? Do you need a tampon?” There is a social structure that needs to be addressed somehow, but practitioners also need to take young girls and adolescents more seriously so that they can intervene early, rather than poor mental health being suppressed because the girl feels that nobody will take her seriously until self-harm and more severe issues come out.

Rachel Stewart: Some of the research on the health behaviour of school-age children was done through the child and adolescent health research unit at the University of St Andrews. It looked at the mental wellbeing and emotional resilience of young people, and at the rates of depression among them. If we look across the board, we see that girls and boys tend to be fairly even at the age of 13. At 15, boys still seem to be quite level—I am using my hands, which will not be very helpful for the official reporters—but there is a drop in the mental wellbeing of girls. There is a general drop, but there is a sharper drop for young women.

The researchers have posited that this is due to exam pressure—young women seem to feel more distressed about the pressure of exams. Social media and body image certainly have an impact on their mental health and wellbeing as well. It is hard to tell, because we know that there are protective factors around peer issues and positive feelings about school. Whenever there are negative feelings about school and the feeling that, “I must pass these exams or my life will be finished,” that is not helpful.

To make things better, we need to teach young people how to cope and how to become more resilient and more able to face what life throws at them, rather than just saying, “Here’s how to cope with exam pressure.” It needs to be more about how to deal with everything and then the exam pressure may not seem as bad.

Alison Johnstone: A lot of the written submissions focus on rejected referrals. There seem to be different views about why referrals might be rejected. Some organisations suggest that they might be rejected to avoid an increase in waiting times. Others suggest that they might be rejected because they were inappropriate in the first place and could have been picked up at tier 1 or tier 2. Do we need to review how we refer?

Rachel Stewart: We need a wider review of how we refer and what is happening at tier 1. When GPs or teachers are approached by a young person about their mental health, we would hope that they are equipped enough to recognise that the young person in front of them needs some support for their mental health, and needs it fast.

Without a review, it is hard to tell whether referrals are rejected because they are inappropriate or because people do not want to increase the waiting lists and waiting time gaming is going on, as we simply do not know how many young people are coming forward at a tier 1 stage asking for support. As Michael Gowan said, young women may be getting an inappropriate response at tier 1 such as, “You’re a teenager—you’ll grow out of it,” “It’s puberty,” or “It’s your period.” It might be that people are seeing CAMHS as something that only begins at tier 3. Universal services need to be able to cope with the mental health of children and young people as it is presented to them.

Michael Gowan: Another point that came up in our research was about how resources such as school counsellors may be very stretched. Our report includes the following comments from respondents:

> “‘You have to be put on a list and wait months to see the school psychologist - not good.’
>
> ‘My school counsellor has a waiting list of 170 people.’
>
> ‘Counselling sessions are … infrequent.’”

When you have those issues inside a school, the school feels that it cannot cope with the young person and it naturally wants to refer the young person onwards. The school might have the resources, but the capacity is not there because the resources are too stretched.

As for meeting waiting time targets, some practitioners have told me since the research came out that they have had reports of young people basically being handed information pamphlets at their first meeting and then sent on their way as a way of dodging that first waiting time target.

I am not convinced that it should all be focused on waiting times. That might be part of it but there are other ways to get round that if you do not want to flag it up in the system. It may be more about

the fact that tier 3 does not have enough community psychiatric nurses to support young people and tier 1 does not have the training or it does not have the resources to support the staff who do have the training, and they are kind of bouncing off each other.

Rachel Stewart: The other challenge is that the waiting time target is only a snapshot of the access point into CAMHS. We do not know what happens after a young person goes into CAMHS; we do not know how long they wait between appointments; we do not know what community support they are receiving; and we do not know whether, at the end, once they turn 18, they feel that they have made a recovery or they are moving into adult services. If they move into adult services, we do not know what impact that move is having on their mental health.

The picture that we have is patchy and not quite good enough, from our point of view. The young people we have spoken to have not been terribly happy about their experiences, whether they are within the CAMHS system, having been assessed as requiring more intense support, or whether they are among the 6,000 a year whose referrals are being rejected and who are then left with nowhere to go. Their GP or someone has said that they need additional support and the specialist support service has told them that they do not, so they are in no man's land. Everyone has mental health and those young people are not being serviced.

11:45

Maree Todd: I want to ask you specifically about the age of eligibility for CAMHS. We had a bit of discussion about whether people should be able to access adult services at the age of 16. My experience of working in psychiatry is that I had concerns about people coming into adult services at the age of 16 when they were still vulnerable—some young people are vulnerable right up to their late teens or early 20s—and an adult psychiatric hospital was probably not the most appropriate place for them to be cared for.

When I worked in psychiatry, decisions were made—in the Highlands and Islands, at least—on the basis of whether someone was still in full-time education, and that was how the judgment was made about whether they qualified for CAMHS or adult services. The difficulty that I had with that was that I saw many people who had such severe illnesses that they had to come out of education. They needed to go back into education but, because they were in adult services, they did not have access to the specialist support to get back into education. Mental illness at any age is hard enough, but having mental illness at a time when it disrupts your potential to fulfil your educational ability can have a devastating impact on the rest of your life. What do the witnesses think?

Michael Gowan: On your point about using adult services at the age of 16, young people have very clearly said that they need their own service, rather than having to go up to adult services that are inappropriate. Some CAMHS units are trying to provide a bridging service, because there are issues when people turn 18 and the waiting time for being seen by a CPN suddenly triples. At that age, young people are moving away from school, their friends have left for university and they are expected to either get a job or go to university, or they end up in the benefits system, which can be quite stressful. It is not about putting young people into an adult service; it is about creating a more bespoke service for the issues that they are likely to face during that transitional period.

Rachel Stewart: SAMH has called for a review of the age at which people can access CAMHS. If young people are vulnerable and they need additional support, stopping CAMHS support at 16—as it is for some health boards; for others, it is stopped at 18—is not appropriate and they should continue to receive specialist support until they are 25. We know that brain development continues until they are 25 so the idea follows that fact, as well as the Children and Young People (Scotland) Act 2014, which looked at how vulnerable people should receive support beyond their 18th birthday.

You are right about the NHS boards—for young people who are not in full-time education there is a cut-off point at about age 16 in places such as Dumfries and Galloway, Lanarkshire, Shetland, Tayside, and Ayrshire and Arran. The NHS has said that it wants CAMHS to be provided to 18-year-olds and those health boards are working hard to achieve that. That also has an implication for the pool of young people who would be going forward ineligible for CAMHS support.

I spoke to a young woman on Friday who has been receiving support from SAMH since she was referred to CAMHS at the age of 16. She is now 20, so she has been in children's services for two years and in adult services for two years. She said that, when she hit 18, that was the end and it was like dropping off a cliff. She had built up a relationship with her CAMHS nurse over two years and she felt that she had been making some progress. She had had a very difficult time when she was 17 and she was detained in a mixed adult ward—which was a terrifying experience for her—but she had nevertheless made some progress. When she hit 18, that was it and she was into adult services. There was no transition from children's to adult services and there was no discussion with her. She knew that it was coming, but it was not made clear to her what it would mean for her support.

The approach taken by adult services was totally different from that taken by children's services, so she felt that everything that she had been doing with her clinicians for two years beforehand had been a bit of a waste of time. She was very angry about the way she had been treated, because she felt that there was no continuity or logic in the situation. She had just been suddenly abandoned to adult services, and she did not have the kind of support that she felt that she needed. She is still a vulnerable young woman—she is only 20.

From that point of view, we think that there needs to be an extension and a much more specialised service for young adults. If mental health problems develop at that stage and young people can receive consistent levels of support, as they are developing into adulthood, they are much more likely to make a recovery. Jessica told me that she took a step back when she went into adult services. She felt very challenged by the new system and it set her back. If she had had more of a transition and a joined-up approach, she might have been able to accept things and could have been a bit further on than she is now.

Michael Gowan: There is also a fairly harsh effect on young people who are waiting to go into the system. If your mental illness is not diagnosed until you are, say, 16 or 17, and then you are told that you are on a waiting list, then at the end of the waiting list you go on to an adult waiting list, which is completely new and has completely different times, and you have to wait on that before receiving an adult service, that can give you a powerful feeling of not being wanted or a feeling that nobody is taking you seriously. One young person said:

> "I'm on a waiting list for CAMHS, and have been told I'm waiting for them to hire a new psychiatrist! They've told me I'll be waiting around 8 - 10 months. I'm nearly 18, so I bet I just get passed on again."

Young people are feeling that the system is dealing with them as a number to be passed on, and you can imagine the sort of effect that that will have on the mental health of someone who is already at tier 3 and how much more difficult it will make their road to recovery. That is something to be aware of. Those who are affected are not just people in the system but people who are waiting to get into the system.

Clare Haughey: I am aware that NHS Greater Glasgow and Clyde changed the transition from adult mental health services to older adult mental health services, so that it is now much more needs led. There is no longer a cut-off whereby when someone turns 65, their care is automatically transferred. I am not sure whether that is happening across the country, but it is interesting that some health boards have acknowledged that, at that end of our lives, it is not particularly helpful for our care to be transferred to another service.

The Convener: The committee has said that health inequality is one of our priorities. I do not have a mental health example, so I use the example of dyslexia. In my area, which is one of the most affluent areas, the level of identification of dyslexia is much higher than the level in the poorest areas. Are you finding similar trends with regard to mental health issues? In affluent areas, are diagnoses of autism or attention deficit hyperactivity disorder happening more quickly and at higher rates than in areas of multiple deprivation?

Sophie Pilgrim: No. We ran our postcodes through the Scottish index of multiple deprivation and found that we are more likely to support families in quintiles 1 and 2, which are areas of higher social deprivation. It is interesting that, for all our projects, the level of support is highest in those areas. It drops off for the middle quintiles, before rising again a bit for quintile 5. We provide our support disproportionately to families in areas of high deprivation.

I know that that goes against what most people believe to be the case, but my experience is that families are desperate to support their children and go to huge lengths to do so. We are missing the fact that parents are a huge resource. However, they come away from treatment and support feeling very belittled and demoralised. One of the reasons why families come to our service a lot is that they feel criticised. They feel that they are being told that their child's condition is to do with their parenting whereas, if we look at the evidence, we see that, statistically, there will be children with extreme needs across all sectors of the community.

Rachel Stewart: There are definite trends among looked-after children, who have higher rates of poor mental health. There are a variety of trends. Some young women from less-deprived areas seem to feel under more pressure with regard to their mental health during their adolescence than do other demographics, so it is a mixed picture.

The Convener: What can be done about inappropriate referrals and underreporting or overreporting?

Rachel Stewart: That comes back to education. Children and young people need to be supported from an early age. They need to learn how to look after their mental health, learn how to look for signs of poor mental health and be supported to ask for help at an early stage. Through the Children and Young People (Scotland) Act 2014, there are duties on public services in Scotland to have regard to the United Nations Convention on

the Rights of the Child, which is all about services listening to the opinions of children and young people to inform their decisions and ensuring that there is an "ask once, get help fast" approach. A young person does not go to bed on a Monday night and wake up the next day needing tier 3 CAMHS. We need to move backwards and start thinking about how we can help young people at an earlier stage, give them the confidence to ask for help and respond to them appropriately when they do.

Michael Gowan: One point that came up in our research is that personal, social, health and economic education—PSHE—has been failing young people, in effect. There is a patchwork at best. I do not think that PSHE has been updated since 2008—although please do not quote me on that; certainly, it has been several years since it was updated—it predates curriculum for excellence. If ever an organisation approaches Education Scotland about that, the response is invariably, "It is down to local authorities and individual schools," so there is a remarkable patchwork in how much support is offered and how much mental health training is available.

One young person said that they had one session on mental health in PSHE in the six years that they were in school and other young people said that it did not show up at all in PSHE, which was about how to write application forms, such as those to get into university. There is not enough in PSHE about how we build young people's resilience and ensure that they are able to survive outside the school environment, or inside the school environment—how they deal with exam pressure, for instance. I spoke to a local CAMHS worker who said that she gets about twice as many referrals for self-harm, anxiety and stress when it is coming up to exam period because so many young people are crumbling under the pressure that we are putting them under and PSHE in the schools in the area is not as good as we would hope for.

It might be worth the committee's while linking up with the Education and Skills Committee to consider how we develop PSHE guidance on mental health, how we ensure that there is a universal standard and how we get it inspected in schools so that it is being met and builds young people's resilience, so that what I describe does not happen as much and, at the very least, young people are able to recognise for themselves when they need to ask for help and are then confident enough to do so.

The Convener: I said that I would try to keep to time. Does anyone else want to come in briefly?

Alison Johnstone: I have a very quick question. Many of the submissions indicate that demand outstrips the capacity of services, and that is coming across in the evidence. The British Psychological Society states that just 0.46 per cent of the NHS budget is spent on CAMHS. Are our witnesses aware of that? Is it an area that requires greater investment?

12:00

Sophie Pilgrim: Yes, 0.46 per cent is spent on CAMHS, and 5.81 per cent of spending is on mental health services, so children really are losing out in terms of the proportion of spend. Where is the early intervention there? Surely we should be investing in children and young people.

A psychiatrist described young people's development to me as being like a plane taking off. They develop so fast during the adolescent years, when they should be learning the resilience and skills that they need for later life, that if mental health issues take them out of the picture, they will not recapture those skills. I would argue that putting more resources into child and adolescent care would be a really positive investment.

Michael Gowan: Rachel Stewart and I are both eager for the mike.

One of the things that occurred to me as Sophie Pilgrim was saying that was that Maureen Watt has said that the Government is investing £150 million in mental health over the next five years. That sounds impressive but, when we break it down, it is £30 million a year and there are 32 local authorities, so it is about £900,000 per local authority. There are eight priorities in the strategy, so that is about £115,000 per strategy, which means £115,000 for children and young people, assuming an equal distribution per local authority—and rural areas and the Western Isles will probably not get as much as Glasgow, for example.

I did not know the statistic, but it does not surprise me. We say that mental health has so much, but when we start chipping away and breaking down how much is ring-fenced for youth services, we see that it is not actually very much. We hear the big headline figure, but when we look, we see that it is not so much. How much could we afford for young people with £115,000? It would provide three community psychiatric nurses for tier 3 cases per region, if that.

Rachel Stewart: It is very hard to put a price on how much we should be spending on CAMHS until we fully evaluate the demand for such services. At the moment, it is one of those limitless amounts, because we do not actually know how many young people are seeking help from tier 1 and tier 2 services—measurement starts at the tier 3 end of things.

We know that the Scottish Government has increased investment over the past few years and has earmarked £54 million for CAMHS over the next few years. Some of that has already been set aside for certain spending in relation to workforce development, service delivery and evaluation. We need a wider review, because then we can put a price on what we need to spend.

We very much want some of the funding to be targeted at the early stages. There have been improvements in the volume of staff working in Scotland. We are now at almost 18.2 CAMHS staff per 100,000 of population and the goal is 20 per 100,000. We can increase the workforce and the supply side of things, but until we actually start helping young people to manage their mental health, the demand for services is not going to dry up, and all the supply in the world will not be able to meet the demand. We need a wider review so that we can fully evaluate the need and start supporting young people the first time they ask for help.

Alison Johnstone: Okay, thank you.

The Convener: I thank the panel very much for their evidence this morning. We will have another session on CAMHS next week, and then a session on adult mental health and a further session with the Minister for Mental Health later in the month.

12:04

Meeting continued in private until 12:36.

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