OFFICIAL REPORT
AITHISG OIFIGEIL

Public Audit and Post-legislative Scrutiny Committee

Thursday 21 September 2017

Session 5

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PUBLIC AUDIT AND POST-LEGISLATIVE SCRUTINY COMMITTEE
21st Meeting 2017, Session 5

CONVENER

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

DEPUTY CONVENER

*Liam Kerr (North East Scotland) (Con)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Caroline Gardner (Auditor General for Scotland)
Richard Robinson (Audit Scotland)
Nichola Williams (Audit Scotland)

CLERK TO THE COMMITTEE

Terry Shevlin

LOCATION

The Adam Smith Room (CR5)

Scottish Parliament

Public Audit and Post-legislative Scrutiny Committee

Thursday 21 September 2017

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

Decision on Taking Business in Private

The Acting Convener (Jackie Baillie): Good morning and welcome to the 21st meeting in 2017 of the Public Audit and Post-legislative Scrutiny Committee. I ask everyone in the public gallery to switch their electronic devices off or to silent mode so that they do not interfere with the work of the committee—actually, there is nobody in the public gallery at the moment.

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

Members *indicated agreement.*

"NHS workforce planning"

09:00

The Acting Convener: We move swiftly on to agenda item 2, under which we will take evidence on the Auditor General for Scotland's report "NHS workforce planning: The clinical workforce in secondary care". I welcome the Auditor General, Caroline Gardner; Richard Robinson, who is an audit manager at Audit Scotland; and Nichola Williams, who is an auditor at Audit Scotland.

I invite the Auditor General to give an opening statement.

Caroline Gardner (Auditor General for Scotland): Thank you, convener. The report, which is the first part of a two-part audit on national health service workforce planning, focuses on the overall arrangements and, in particular, on clinical staff who work in secondary care such as hospitals. Part 2 of the audit, which will be published in 2018-19, will look more closely at the community-based workforce such as community nurses and general practitioners.

Thousands of people work hard in Scotland's NHS to deliver vital public services, but there are signs that staff face increasing workload pressures. Some of those are shown in exhibit 2 on page 13 of the report. Overall, patient feedback about the NHS and its staff is positive, but complaints are rising and staff continue to voice concerns about their workloads. Spending on NHS staff has increased to £6.5 billion, but most health boards overspent against their pay budget, and agency staff costs are increasing.

The Scottish Government intended to publish a national workforce plan for health and social care in the spring this year. The plan is now being published in three stages. The first part, which was published in June, covers the NHS workforce. In previous reports, I have highlighted the need for a clear workforce plan to ensure that there are the right staff with the right skills for new ways of working. The published plan does not set out detailed actions to deliver that workforce; instead, it provides a broad framework that sets out the challenges ahead and further work to be done.

Demand for health and social care services is expected to continue to rise, but neither the Scottish Government nor NHS boards have adequately projected how that will affect the workforce numbers or the skills that are needed in the longer term. The Scottish Government's processes for determining training numbers are largely based on replacing current numbers in the workforce, with some consideration of previous years' growth.

There are also concerns about sustaining the current workforce. Vacancies for some consultant and nursing positions remain high and are proving difficult to fill. In addition, upcoming retirements may increase vacancy levels in parts of the NHS. For example, over a third of the nursing and midwifery workforce is over 50, and the number of newly qualified nurses in Scotland who were available to enter the workforce fell by 15 per cent in 2014-15 and a further 7 per cent in the following year.

The national workforce plan recognises that, between 2017 and 2020, the number of existing students who will enter the workforce will not be enough to meet demand, and it states that around 2,600 additional nurses and midwives will be needed by 2021-22. That figure may be an underestimate. As I said, insufficient work has been done to determine what future demand will be, and there are shortcomings in the data on how many nurses may retire in that period, as well as other factors such as the impact of Brexit.

Finally, responsibility for NHS workforce planning is confused. It is shared between the Scottish Government, NHS boards and regional planning groups. The development of health and social care integration authorities and new elective centres may add to that confusion, and separate planning processes for doctors, nurses and other professional groups make it more difficult to consider how skills across different groups in the workforce will complement each other.

The NHS is undergoing major reform, but the funding that is needed to support that does not clearly identify the expected workforce costs associated with the changes. To improve workforce planning, more clarity is needed on lines of responsibility, the workforce supply and skills available, and the needs of the Scottish population in future.

As always, my colleagues and I are happy to answer the committee's questions.

The Acting Convener: Thank you very much.

Colin Beattie (Midlothian North and Musselburgh) (SNP): Overall, the report is not a bad one, but there is a bit of déjà vu here. It seems that we have been talking about proper and effective information gathering in the NHS for years now. Has there been any improvement at all?

Caroline Gardner: I share that frustration. We know that the workforce is central to delivering health and social care, and we have known for a long time that those challenges were coming. There have been recommendations from Audit Scotland and others over a long period on tightening up the planning, getting the detail in place and basing that work on analysis.

There have been some improvements, and the plans that are coming through are certainly more detailed than the visions that we have seen in the past, but there is still a way to go. Richard Robinson may want to add something on the specific improvements that we have seen.

Richard Robinson (Audit Scotland): With regard to the modelling that is carried out, we refer in the report to how the Scottish Government arrives at the numbers that it puts in. We have seen an increase in its use of data on retirements from the workforce and so on in order to build a clearer picture but, as the report says, there is a lot more to be done to bring together the necessary information and data to make informed decisions on the workforce.

Part 1 of the national workforce plan, which mirrors our report's recommendations, sets out that NHS Education for Scotland will have much more control in order to build up a picture of the supply chain for doctors and put together various bits of data that are held by different people. We illustrate that in exhibit 10 in our report.

Some progress has been made, but it is not sufficient to enable the NHS to build a full picture of what the workforce looks like now, which is important in order to understand what is needed in the future.

Colin Beattie: Does Paul Gray's submission fill you with confidence?

Caroline Gardner: It reflects the position at the moment, which is that part 1 of the workforce plan was published in June. There is a lot of work to do to get the next two parts out by the end of this year, and there are many commitments in the workforce plan on the work that is needed to fill in the gaps and get the detail in place. The commitments are the right ones, but the timescale is ambitious, and we will be looking closely at the progress that is made as we work towards our second report in the area, which is to be published late next year.

Colin Beattie: Picking up on Paul Gray's submission again, I note that the last paragraph refers to allocations for

"funding for ... reform of services in future years".

When will you be looking at that?

Caroline Gardner: As I said, we are planning to publish a second report next year on workforce planning in primary and community services in particular. It will include an update on progress against the commitments that have been made.

Reform is a theme that comes through every year in our annual report on the NHS as a whole. In that report, we provide a high-level picture not only of what the workforce looks like, including the

level of vacancies and so on, but of the progress on putting in place the detailed and costed plan for reform and transformation that we have recommended in the past and for which the Scottish Government accepts the need. There has been some progress on that but, again, we have not yet seen the level of detail on cost, staffing, infrastructure investment and so on that is needed to make it a reality.

Colin Beattie: You mentioned staff costs in your initial statement. Spending on NHS staff has increased by 11 per cent. Is that in real terms?

Caroline Gardner: Yes.

Colin Beattie: That is quite a lot. Does that include agency staff?

Caroline Gardner: Yes. My team will keep me right, but I think that it is the figure for total spending on staff.

Colin Beattie: As you highlight in the report, the number of agency staff has increased by 107 per cent in six years, to £171.4 million in 2016-17. Paragraph 22 of your report states:

"Nursing agency costs have risen from £4.2 million ... to £24.5 million ... in real terms."

What is the balance—nearly £150 million—of the agency costs? Do we have a breakdown of those costs?

Caroline Gardner: We cannot break the costs down as much as we would like to, because there are published data only on nursing agency costs. Nichola Williams can talk you through the data that we have as far as those figures are able to support the picture.

Nichola Williams (Audit Scotland): The only data that are published are the nursing and midwifery agency costs. We have taken the figures for total agency costs from the board accounts, but those are not broken down by staff group at all, and we do not know how many people there are. We just know the overall cost. In one of our recommendations, we discuss the importance of collecting more detailed information on agency costs.

Colin Beattie: That is ridiculous. It is nearly £150 million. Surely we know what we spent it on.

Caroline Gardner: We know in broad terms that the bulk of the money is likely to be spent on medical staff. Members will have seen in the press reports that some very high sums have been paid to individual doctors when it has been essential to fill a particular gap. However, that information is not analysed and published across Scotland in ways that we can use in the way that nursing agency costs are. As we say in the report—and as you are reflecting—that is an important omission.

Colin Beattie: Do we know whether the Scottish Government is moving towards publishing a breakdown of the figures?

Richard Robinson: This is one of the data issues that we highlight in the report as part of the need to improve some of the data. In paragraph 52, we highlight that very issue about the published data not being broken down sufficiently by staff group, and we state that improvements need to be made to the published data on vacancies.

I think that the Scottish Government has acknowledged that more needs to be done to collect the information that it needs in order to look more specifically at vacancies and at how to control agency costs. We recommend that it should collect that data at a more granular level.

Colin Beattie: I presume that Audit Scotland asked for that information but it was not available.

Caroline Gardner: Absolutely. As Nichola Williams said, the information that is available is in the individual health boards' accounts, and their ability to break the figures down varies. That raises its own question about how well people are able to manage those costs, particularly in the context of the new managed agency staff network that has been put together to try to bring the costs down safely across Scotland. The starting point should be a good analysis of what we are spending and where so that we can tackle the pressure points.

Colin Beattie: Paragraph 22 of the report refers to nursing agency costs having risen from £4.2 million to £24.5 million. I think that it was mentioned just now that the figure includes midwifery.

Caroline Gardner: Yes.

Colin Beattie: Do we know the breakdown between the two?

Caroline Gardner: I do not think that the figures break it down in that way; I think that they treat nursing and midwifery as a single group of staff. That is another feature of the lack of precision in the data, which makes it harder to tackle the problem.

Colin Beattie: Paragraph 22 also reveals that the average annual cost of agency nursing staff—I assume that the figure is for nursing staff and does not include midwifery—is £88,000, compared with £38,000 for directly employed staff. That seems a huge differential.

Caroline Gardner: The figure is for nursing and midwifery staff rather than just nursing staff, because the data is pooled. You are right that there is a huge differential. It reflects the fact that agencies are private organisations that are

operating in a market, as opposed to the NHS managing its own staff more directly. In many cases, it reflects the fact that, where a gap has to be filled by agency staff, there is very little room for manoeuvre as the staff member—the nurse—needs to be in place, so the bargaining and negotiating power is not as high as it would be in other circumstances.

Colin Beattie: In the audit, was there any indication that the NHS is endeavouring to control those costs?

Caroline Gardner: Yes—I think both nationally and at health board level. I ask Richard Robinson to talk you through what the team saw in that area.

Richard Robinson: We cover the issue a bit more from paragraph 23, which mentions a group called MASNet—the managed agency staff network—that was put in place from December 2015. Its aim is to look at the issue a bit more closely, to establish whether—at a variety of levels—there is a process by which agency costs are approved and to identify when they are used and what is happening behind the figures. As the report states, although agency costs have risen, we saw a small drop in the past year of about 3 per cent.

Boards are also trying to look at ways that they can work more regionally so that, if there is more than one NHS board in a particular region and one board requires staff but cannot get them through its bank, it can look to its partner boards in the region to see whether they can pool some of those resources. As is pointed out in the director general's submission and in part 1 of the national workforce plan, two of those regional boards were set up in March 2017. We will see in due course what impact that has on agency numbers.

09:15

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): Good morning. I want to touch on some broader issues about audit. As you know, Auditor General, I have been a member of the committee for a number of years. The reports that you give the committee are excellent, but we always ask, "What happens next?", and we want to know how we achieve the benefits and make the improvements that you are hoping for in your recommendations. Do we still need to strengthen that part of the audit cycle?

The key purpose of audit is to promote continuous improvement. Your organisation spends a lot of time doing its good work, and the Scottish Government responds to it, but then what? Should there be another stage in the process where someone—the Government, the committee or Audit Scotland—revisits your reports, such as the one that we are considering today, perhaps in a year, and produces another report on the evidence for improvement on the issues that you have raised. Do you have any thoughts on how we could make that process even better than it is at the moment?

Caroline Gardner: That is a really good question, and one that, as you would expect, we in Audit Scotland think about a lot. We spend our careers doing this work, and we do it because we want to make a difference and not just because it is a cosy way of making a living. There are two levels at which that process works currently. One is that our auditors follow up at local level what individual health boards are doing as a result of the recommendations in our national reports, and the second is through the role of the committee, which places powerful expectations on Government directorates and public bodies that they will accept our recommendations and act on them or, if they think that we have got it wrong, be very clear why they do not accept them. It is worth considering whether we can strengthen both parts of that process.

One caveat is that, although in many areas we follow up the work that we have done—we will track progress on this report with the one that comes next, in 2018-19—the more follow-up work we do, the less time we have to look at new areas. There is always a trade-off between picking up new areas that are rising in importance or are simply new to public services versus following up on what has happened. However, we would be happy to have a conversation with the committee and its clerks to think about whether there are things that we can tighten up in the system and how we can learn from bodies such as the Westminster Public Accounts Committee and the Welsh Public Accounts Committee.

Willie Coffey: I am reminded of one of Jackie Baillie's former colleagues, George Foulkes, who sat on a predecessor committee. He frequently asked, "Now what?" and "What do we see next?" You have said that you look at whether recommendations that are accepted are being carried out, but how would we as a committee see that and how would the public generally be made aware? For example, would it be useful if at some stage the NHS had to produce a response to the report, perhaps for the committee or the public, so that we can scrutinise where gains have been made?

Caroline Gardner: It is worth considering. I am conscious that two members of the committee were in Wales on Monday this week talking to their counterparts in other public audit or public accounts committees. In Westminster, there is a specific role called the Treasury officer of accounts, whose job it is to provide an annual update to the Westminster Public Accounts

Committee on progress on National Audit Office recommendations. That is done in a systematic way that helps that committee to keep track of the impact of its work. It is worth considering something like that in the system in Scotland.

Willie Coffey: To take a specific example—I am not picking it for any particular reason—the diagram on page 9 of the report sets out the workforce numbers, which are broken down into various groupings. The figures on the right-hand side of the diagram show that administration services, support services and the "Other/not known" category account for 37.5 per cent of the entire workforce in the NHS, which is staggering. If some improvement process was looking at that, how would we know that improvements were being made in that area? How would that be evidenced to you and then to us?

Caroline Gardner: We have not looked in detail at those other groups of staff, and it is entirely possible that all those staff are doing important jobs that help to keep health and social care services running. Equally, given the number of staff who are involved, it is unlikely that there are not savings or efficiencies to be made or better ways of working. All that we can do is report the change in the number of staff and the breakdown in the next place that we go, but it is entirely appropriate to ask Government what approach it is taking to ensure that all staff have the maximum impact on patients' experience and wellbeing, rather than being a cost that could be better used in other ways.

Willie Coffey: If, during the follow-up inspection or verification, you see improvements in a particular health board, do you try to find out whether those improvements are being evidenced in other health boards, or is it really up to them to embrace the changes?

Caroline Gardner: We work quite hard at sharing the good practice that we see, both through our reports and through engagement in a range of ways that are not visible to the committees. Increasingly, the teams that do the audit work are talking at conferences, going out and engaging with local NHS boards and working alongside the auditors who work on the annual audits of the accounts to help them to understand what they are seeing when they look at the numbers. Again, however, there is a trade-off between how much of that work we can do and how much new work we can do on your behalf.

Willie Coffey: Thank you for that answer.

Alex Neil (Airdrie and Shotts) (SNP): I want to follow up on Willie Coffey's point. The committee should ask the Government for a breakdown of those two large figures on the administrative and support staff. We should ask the Government directly about that; no doubt we will invite Paul Gray in to discuss the report.

I will start with agency nursing. There was a rule that nurses living in a particular health board area could not be employed as agency staff for that health board. As a result, costs have increased because by definition, agency staff have to be recruited from outwith the health board area in which they live. Recently, I had a case where an agency nurse living in Fort William was working in a central belt health board, which meant that in addition to the cost of their shift—they were getting about 80 per cent more than the nurses employed by the NHS whom they were working beside—they got the costs of their travel to and from Fort William, their overnight stays and breakfast and dinner. Can you clarify whether the rule remains that an agency nurse must come from outwith their board area?

Richard Robinson: Our understanding is that the policy is up to the NHS board. In general, boards prefer additional staff needs to be met by the bank as opposed to the agency, because, as we point out, it is cheaper. They want to encourage nurses to be part of the bank. That means you can end up with a situation where the board says that it does not want to overtly encourage people to join an agency before a bank and so it puts in place such a policy. The growing picture around regional banks that we mentioned earlier is about being able to control that further, by being able to call on banks between particular areas.

As you point out, the costs of an agency nurse or doctor also involve getting them there and keeping them there; those are all additional costs. The question is how we ensure that we retain the flexibility that banks and agencies allow—being able to cover shifts and keep services running—in the most cost effective way. The NHS view and that of MASNet is very much to encourage the use of bank over agency wherever possible.

Alex Neil: I know that, but the point is that, in individual cases, the rule adds to the cost enormously. Given how strapped for money the NHS is, that clearly needs to be looked at urgently in order to reduce costs. In the example that I gave, the costs must be exorbitant. That is not to mention the impact on the morale of the NHS nurses who are working beside people who are getting substantially more money for the same work and length of shift.

Bank nurses are already employed as NHS nurses, but they do not get substantially more than the people they are working beside and they live in the board area. It seems a bit daft—to say the least—that we have a rule that adds to costs unnecessarily. That is something we should ask about when we have Paul Gray in front of us.

The second point that I want to clarify is also on agency nursing. At the top of page 15 of your report you say:

"Nursing agency costs have risen from £4.2 million in 2011/12 to £24.5 million in 2016/17, in real terms."

Is that the amount of money going that is to the private nursing agencies?

Richard Robinson: Yes.

Alex Neil: That is their fee, so £24.5 million in private nursing agency fees is being sucked out of the NHS. When I was the health secretary, I specifically asked that we arrange agency nursing inside the NHS—that we would do bank nursing—to avoid having to pay those fees. Clearly, that has been totally ignored.

We could save that £24.5 million pretty quickly by bringing the whole operation into the NHS so that the £24.5 million would circulate within the NHS instead of among the private nursing agencies—which also, by the way, recruit for boards down south and internationally. We are feeding them the information and the people, some of whom get taken away from the Scottish health service to work in health services south of the border or abroad. In my area, one is advertising a big exhibition at the moment, saying, "Come and join us and get new nursing opportunities all over the place." The very people we are paying to do this are also simultaneously encouraging nurses to leave the health service in Scotland and go elsewhere. I just wanted to clarify that point.

I turn to the slightly different matter of the overall issue of supply, and the helpful exhibit 10 on page 30 of the report. It is clear that we will continue to be short of consultants, GPs and other medics if we do not have enough coming in from the very beginning, right at the top. At the moment, there are nearly 5,000 medical students in Scotland. We have 5,500 consultants and roughly the same number of GPs, or just under that—we have about 5,000 GPs in Scotland. If the pipeline of people who go into training is not sufficient, in five or 10 years, we will not have the number of people that we need, let alone in the right specialties.

Do you know three bits of information about the bit above the number of medical students, as it were? The first is the number of people who apply to medical school from school. Is it possible to get those figures? If the Auditor General cannot do that, maybe the clerks can do it through the Scottish Parliament information centre. How many people from Scotland apply to medical school in Scotland and have the qualifications for entry but do not get accepted? My understanding is that probably about 90 per cent of those who apply and who have the qualifications to get in do not actually get in. One of the issues is that we are not creating nearly enough places for indigenous students to get into medical school in the first place. I am not talking about dumbing down the qualifications; I am talking about people who are qualified to enter. We need that information.

Secondly, what are the drop-out rates in years 1, 2, 3, 4 and so on? It is clear that they can be quite significant.

The third missing part is the place of residence of the applicants. There is clear evidence internationally that medical students tend to end up practising medicine in the country where they were resident before being a student. There is also clear evidence that a high proportion of medical students from rural areas—compared with the population as a whole—end up practising in rural areas, although not necessarily the one that they came from.

Those things matter. My understanding is that a high proportion of places in medical schools in Scotland are not for students from Scotland. We should not take away from those other students—a lot of benefits come from having students from down south and elsewhere—but we need to create more places for people from Scotland.

If we can get that information from the Auditor General, SPICe or the Scottish Government, it will give us a better picture. We have to look at the long-term picture because it takes 10 or more years to go from student to consultant. If we do not have a big enough pipeline at the beginning, we will continue to end up with shortages as we go forward, both overall and in certain specialties, including general practice. Do you want to comment on that, Auditor General?

09:30

Caroline Gardner: We did not look at those issues in detail as part of this audit, but you may recall the report that we did a couple of years ago on higher education, which shows that it is getting harder for Scottish students to gain a place at Scottish universities because of the way in which the number of places has changed and the link with tuition fees. There are questions to be asked about the medical school intake. Richard Robinson might want to come in on that in a moment.

The other thing that I was going to say has gone straight out of my head, so I will hand over to Richard now while I try to remember it.

Richard Robinson: Alex Neil talked about drop-out rates and understanding the pipeline better, which is exactly the kind of thing that we are trying to map out in exhibit 10. We recommend developing a better understanding of how all the bits fit together. Nursing has a shorter time

pipeline than consultancy. Case study 2 on page 29 shows how NHS Education for Scotland is able to track nurses through the system and see when people leave and where they go.

In part 1 of the national workforce plan, NHS Education for Scotland has been given the responsibility of looking at the medical workforce in more detail, alongside the General Medical Council and other partners, and trying to better understand where people are going and when. Sometimes people leave the pipeline and return to it at a later point, and understanding that is really important. What you feed in at one end comes out at the other, and we need to understand what happens in between.

As well as an emphasis on numbers going in and the number of Scottish students studying, there is an emphasis on getting students from the right places in Scotland. NHS Education for Scotland has been looking at that with the GMC through UKMED—the UK medical education database—which we mention in the report. Part of that will be considering whether we are getting people from the right geographical areas of Scotland to take an interest in and study medicine. There is some evidence that people are more likely to return to those areas, which might help rural areas and other specific pockets in Scotland where the situation with vacancies is particularly acute.

Alex Neil: I could put loads of questions to you, but these are my final ones.

Clearly, other factors influence the supply of medics, nurses and allied health professionals. I would like your opinion on three issues. First, there is anecdotal evidence that the differentials in remuneration for agency staff, including medic locums and agency nurses, creates a vicious circle in which people leave the health service and—if they are nurses—go on an agency's books because they will get much more money, will have more choice over the shifts that they do, and will be able to work the number of shifts that suit them, rather than having to do a certain amount. As more nurses leave the employment of the health service and become agency nurses, it puts further pressure on those who still work for the health service, and that pressure fuels further erosion of staff because they move from the health service to agencies and other places. It is a vicious circle.

It is the same with locums. Locums used to be used for filling gaps such as those caused by maternity leave, but locums have almost become an industry in their own right. It is the same issue: locums are paid far more than the doctors who are employed by the NHS.

Have you gathered enough information for us to be able to look at the links between the impact that such policies are having, in terms of remuneration, and the impact on the leaving rate in the health service and the stresses that there are as a result of shortages?

There is another factor that relates to medics. Two or three years ago, there was a clear policy decision that there would be a ratio of at least 8:2, and in some exceptional cases 7:3, between being a consultant and the training time allowed for new recruits, because that was beneficial to everybody. I notice that 43 per cent of the consultants recruited last year are still on 9:1 contracts. I suspect that most of that is in Greater Glasgow and Clyde NHS Board, because it has a policy of ignoring national policy, and in my view it needs to be brought to book. There is clear evidence that an 8:2 ratio is far more effective in delivering services and in recruitment. If you have more evidence on that, I would be interested to know whether most of that 43 per cent figure is due to Greater Glasgow and Clyde NHS Board.

Caroline Gardner: I will start on your first question and then hand over to the team for anything that they want to add on the second question.

First, the question of pay differentials with agency staff is interesting. As you would expect, we could not get good data on that. Agencies are private companies and we have no access to their data. Anecdotally, it is likely that most staff working for agencies do not earn much more most of the time. There are situations, as touched on earlier with Mr Beattie, where a member of staff is urgently needed to fill a gap in a specialty that has a lot of shortages, when the agency will offer the staff member more as well as charging the board more, but I do not think that that means that all staff working for agencies are being paid markedly more than their colleagues in the NHS.

Alex Neil: If you talk to nursing staff, they will tell you the opposite.

Caroline Gardner: What they will be focusing on are those instances where there is somebody on the same shift as them who is earning twice as much or an awful lot more because there is a specific need. As I said, we do not have data, so we are both working on anecdotal evidence, but that anecdotal evidence does suggest that not all staff working for agencies—whether they are nursing or medical staff—are earning much more all the time. What those agency staff value is flexibility, and we know that, across the NHS workforce, younger people coming into the profession are much less likely to commit to full-time careers for life. That is one of the big issues that are starting come through in the work that we are doing on primary care. Doctors do not want to commit to being partners who are committed for the whole working week and in many cases for

longer working hours than that, because they want to do other things with their lives. That is not just about young women who want to bring up families or take primary responsibility for that; it seems to be an issue right across younger professionals.

One of the challenges is how we make banks much more attractive in the same way, by giving people flexibility at the times in their lives when they want it, and that is very much driven by their needs and preferences, not by assumptions about young women at particular points in their careers. MASNet has the potential to do that, and the evidence shows that we saw a slight dip in agency costs from 2015-16 to 2016-17. It is still early days, and we cannot show causation yet, but it seems that a lot can be done around making the bank an attractive place to work and integrating it better with those staff who do still choose to be employed on a permanent basis by the health boards.

Richard Robinson: Our report does not have data on the specific motivations of people who choose to work for an agency. Anecdotally, we hear about the flexibility benefits and there could also be pay benefits. As part of the work involved in gathering the information that the NHS needs to make decisions and to look at agency work in more detail, we could choose to pursue that and find out more about it. The view is that an agency is great for flexibility and for filling gaps, but it should be used when necessary if the bank staff cannot be used, and it should be used in a way that is cost effective. The director general's submission brings up the issue of using framework contracts whenever possible. Those are contracts that have set terms and conditions that have been agreed with the Scottish Government to manage those costs.

The 9:1 and 8:2 contracts have been raised by the Royal College of Physicians of Edinburgh, because it impacts on doctors' ability to do their work. With a 9:1 contract, they have just one bit for everything that is not direct work, which might include administration, training and other things. I understand why there is an appeal to get consultants on the floor as much as possible, but 8:2 contracts could be used to increase training time and provide a better balance in the workforce.

Caroline Gardner: Can you say anything about the Greater Glasgow and Clyde question?

Nichola Williams: I do not have the data about how that breaks down in front of me, but it can be provided. The boards that took on the highest proportion of consultants on 9:1 contracts last year were Dumfries and Galloway, where all eight were taken on at 9:1, and Lanarkshire, where 90 per cent—that is 37—were taken on at 9:1. I do not have the full breakdown in front of me.

Alex Neil: It would be very helpful if you provided that.

Nichola Williams: Yes.

Alex Neil: Thank you.

Liam Kerr (North East Scotland) (Con): Good morning. Auditor General, your written submission states:

"The Scottish Government and NHS boards have not planned their NHS workforce effectively for the long term."

In your opening statement, you suggested that responsibility for that planning is "confused". I am always rather uncomfortable when there is a lack of accountability. Are you in a position to say who has dropped the ball? Is the conclusion the same for all boards, or are there different lines of responsibility and different levels of failure in different boards?

Caroline Gardner: The overall approach to workforce planning in the health service is obviously the responsibility of the Scottish Government. As Richard Robinson outlined, it has improved over the past seven years or so, but we still lack the detailed understanding of where the pressures are and what future demand is likely to look like that would enable the Government, the health boards and the new regional planning networks to take the necessary action to make the workforce more sustainable.

There are several challenges. First, most planning so far has focused on filling existing gaps in the workforce rather than on thinking ahead to what demand will be as the population ages, as we see more people with chronic and complex health conditions and as we look at new ways of working across health and social care with the new integration authorities. Secondly, we still plan separately for medical staff, nursing and midwifery staff and other allied health professionals, which makes it harder to work in a joined-up way.

The Scottish Government has overall responsibility, but it is important that the health boards, the regional planning groups, the integration authorities and the new elective centres understand what part they are expected to play. It is a complicated field and, if people do not know what their responsibilities are, there will be a risk of duplication or of things falling between the cracks.

Liam Kerr: The planning that you refer to troubles me. We have a submission from Paul Gray, who has stated that the health and social care delivery plan

"makes clear that scenario planning will help to inform decision-making about how best to use ... skills".

He added:

"We will publish refreshed guidance to Boards early next year which will set out the refinements Boards need to make to the planning they currently do, and also how to project forward the future workforce".

That troubles me, because it is as if scenario planning and workforce planning are new ideas that have never been thought of before. Is not one of the key functions of a board to do scenario planning and workforce planning?

Caroline Gardner: That is one of the key functions of a board. I suspect that committee members are bored of hearing me say that I do not see enough financial planning. It is critical for health boards to plan their likely costs and revenue over a number of years and to think about what could affect that and how they would respond.

The picture is slightly different for workforce planning because of the national input into training, particularly for medical staff but for nursing and midwifery staff, too, and the time that it takes to train a professional from the point that they leave school and go to university to the point that they become a fully fledged member of the profession. The numbers involved for some specialties, particularly in medicine, are actually very small across Scotland, so it is hard for each of the 14 health boards, plus the Golden Jubilee national hospital and the other elective centres that are being developed, to plan individually.

Obviously, health boards have a role in workforce planning, but we said in the report that their projections have tended to be too low in the past. However, there is also a strong national role in ensuring that the numbers entering training are as right as they can be, given the uncertainties that there will always be about future demand.

09:45

Liam Kerr: You are quite right. On page 19 of the report, you say:

"Historically NHS boards have underestimated the size of the workforce".

Workforce planning has been a statutory requirement since 2005, so that rather suggests something to me that I am struggling to understand. Ought not a board member of an NHS board, on a salary that will be not inconsiderable, know that something has to be done and that it has had to be done in statute since 2005? Is it fair to conclude that board members have failed in doing that?

Caroline Gardner: I do not think that it is fair to say that people have failed to do that, but it is certainly fair to say that they have not done it well enough to ensure that the workforce is sustainable at health board level and nationally. I ask Richard Robinson to talk you through why we think that some of that has or has not happened.

Richard Robinson: The stages that have to be gone through for workforce planning can be seen in exhibit 6 in the report. We have found that NHS boards have plans that consider, among other factors, the demography of their areas. However, our concern is that those factors are not being projected through into future years. One of the links that we make around that is that boards receive one-year budgets and the plans under the guidance have to be affordable and achievable. The boards know what the budget is for the next year, so they can make more realistic decisions about what they can get and what they need. However, beyond the next year, they simply make projections that are based, in effect, on what they have now.

One of the report's central points is about understanding future demand for both recruitment decisions and boards' preparations at the regional level. We note in the report that the "Pan Scotland Workforce Planning Assessment and Recommendations" report was produced in 2014 for the Scottish Government and that it recommended scenario planning and suggested options for what could be done. Obviously, I recognise that we are making the same recommendations in 2017, to be taken forward now. I hope that the refreshed guidance will help with boards' projections for future years.

On a more general level, an issue is that there is a big period of reform that involves how things will work with integration joint boards and elective centres, and the levels of responsibility there. We mentioned that in the "Background" section. That is why we are looking to do a second report on the NHS workforce down the line. However, we recommend that scenario planning should be done.

Liam Kerr: If I may, I will take you to the 2014 report. Paragraph 60 of the current report states:

"The Scottish Government does not adequately consider long-term future health demands through its workforce planning process."

You quite rightly pointed out, Mr Robinson, that—I think that I am right in saying this—the Scottish Government recommended in a report in 2014 that it should carry out long-term scenario planning with health boards. However, it does not appear to have done that. Why not?

Richard Robinson: Again, that is more a question to ask the Scottish Government directly. However, we said in our report that, within that context of reform, the Scottish Government was looking to put in place a number of things around understanding the workforce that it has. We said that that should have been actioned in 2014,

which is why we asked for it again in the 2017 report.

Liam Kerr: I have a final question. We are talking as if this is year zero: there were various recommendations and there has been a statutory requirement since 2005, but we are where we are. You are right to allude to a period of change or transition. Have you any confidence that we will not be sitting here in three years' time having the same conversation and asking "Why didn't they act on this?"?

Caroline Gardner: It is certainly a feature of this particular report that recommendations that we have made which go back a number of years and recommendations of others have not been acted on or fully seen through. We have seen a series of plans and strategies, which are set out in exhibit 4 of the report, but we still do not have the detailed understanding of current staffing numbers and spend and the detailed forecasts of future demand that would allow the strategies to become detailed plans that would have an impact. We are looking closely at the issue, and we will be interested to hear the Scottish Government's evidence on that. We will report next year on the progress that we are seeing. There is no doubt that the area is very important for the health service.

Monica Lennon (Central Scotland) (Lab): Good morning. Liam Kerr raised the point about the requirement to submit workforce projections. I am interested in the reference in the report to NHS Ayrshire and Arran and my local board, NHS Lanarkshire, which have projected their workforce for only one year, rather than the three that are required. Some explanation has been given for that, but can you comment further? What are the risks or repercussions of presenting only that one-year projection?

Richard Robinson: As well as looking forward, one of the things that we did was to look back to what that means with regard to the workforce that boards have versus the workforce that they projected. On that first point, we are saying that, traditionally, some boards overspend against their paid budgets, and the issue that you identify could be a reason why that happens. The issue is about the information that they have and what they know about the future. Obviously, their projections are linked to what their costs will be.

On a regional and national level, if there are to be better lines of responsibility and closer working to establish the medium and long-term needs of the workforce, it is important that the Scottish Government and the regions are assured that the projections that they get from NHS boards are realistic and reasonable. We would like to see those as the basis on which decisions are made around training, skills mix and how to use the workforce within a reformed NHS.

Monica Lennon: Does the Scottish Government have to give special permission for a health board to offer only a one-year projection or does the health board have discretion to do that?

Richard Robinson: I am not sure about the details on that. I know that some boards chose to offer only one year and gave the reason that they were undergoing reform and so felt that it was not realistic for them to make those projections. I am not sure how that fits with the requirement side of things.

Monica Lennon: Okay. In paragraph 50 of your report, you talk about the risk that could arise from the sheer number of workforce plans and different workforce groups and how that could become a barrier to effective working. I can see the potential for that to become quite a cluttered area. You have not made any particular recommendations alongside your general observations, so what do you think could be done to mitigate the risk of such clutter? Is there an overabundance of workforce plans and groups?

Caroline Gardner: The relevant recommendation in the report is the one about clarifying those responsibilities for workforce planning. In some ways that point goes back to Mr Kerr's earlier question. All those people have a role to play, but it is important that they understand that role and how the plans come together to build up the national picture, the regional picture and the very local picture within health boards.

At the moment, that situation is confused. In the report, we say that there is a risk that it will become more confused with the new integration authorities thinking about the workforce that they need and the new elective centres that are being established across Scotland. In many ways, that is part of the answer about how to achieve progress and action in that area. At the moment, a lot of effort goes into developing plans and not enough goes into understanding and filling in gaps in the data, or using data to look ahead at the skills and professional groupings that we will need and what they mean for training now and in the period ahead.

Monica Lennon: What simple things could avoid the fragmentation that arises when people work separately and do not get a holistic overview?

Caroline Gardner: The clarification of responsibilities is the big thing. Richard Robinson can add to that.

Richard Robinson: I agree about clarification. Under part 1 of the national workforce plan, a national workforce planning group will be formed

to examine the strategic decisions and decide what level of planning should be done and where. For example, regional workforce plans might be addressed in a more strategic document that sets out such things as the overall skill set of the workforce in the region and how it can best be used.

The national forum for NHS workforce planners will support the various parts and look at how they fit together, including responsibilities and clarity of lines. The first integration authority plans came out this year, and the workforce forum will look at how they will fit into an NHS board plan and a regional plan. There is work to be done and there are decisions to be made. I reiterate that it is important to be organised and ensure that there is clarity around what workforce plan will have what responsibilities.

Monica Lennon: I take the point about the need for clarity of responsibilities. Who is responsible for making sure that that happens?

Caroline Gardner: The Scottish Government is responsible for clarifying the roles in the system as a whole, as it leads the system.

Beneath that, the individual challenges and problems will be different in different parts of Scotland. We have touched on the challenges in rural Scotland, and the report talks about shortages in particular medical specialties. Once it is clear who is responsible for what, it will be much easier to analyse the data and know what the problems are in particular parts of Scotland and to be clear who can take the actions to resolve them. If the problem is how to get more doctors to go into training, that can be addressed only by the Government but if the problem is how to make the local nurse bank more flexible and responsive to the needs of individual nurses and to have more allegiance from people, that will be down to local leadership.

There will be solutions all the way up and down the chain, depending on the particular problem that we are trying to solve.

Monica Lennon: We are often told that staffing levels are at their highest ever. If that is the case, why is the workforce struggling to cope with demand? That is hard to understand.

Caroline Gardner: Our ageing population is a big part of the problem. There is a larger number of older people, and older people tend to have more complex chronic health conditions that last for a long time and to have several things wrong with them at the same time—multiple co-morbidities is the horrible phrase that professionals use to describe that. We can all recognise those issues from our experiences with our parents and relatives. That means that the number of people that is needed to deliver the health service keeps on increasing, as does the amount of money that we spend on the health service, but it is still struggling to keep up with demand.

There are solutions such as new ways of working, which were intended to be a key outcome of the integration authorities. However, they will have an impact only if the right staff are in the right place to work in new ways that will, for example, keep people safe at home for longer or help people to be discharged from hospital safely and more quickly. Progress is slow on that part of the mix.

Monica Lennon: Would it be correct to conclude from what we have heard today that the Scottish Government has failed to adequately plan for not only the numbers of staff but the right mix of skills?

Caroline Gardner: Yes, our conclusion about the inadequacy of current planning covers the range of skills and the range of professionals who are needed, as well as the straightforward numbers. The Government itself has recognised that the answer to the challenges facing the health service is not simply to keep on growing the number of staff but is instead about people working differently in different roles and teams, which obviously increases the premium on getting workforce planning right.

Monica Lennon: Are you saying that there has been a failure to plan adequately for the right mix of skills that the NHS needs?

Caroline Gardner: Yes. At the beginning of key message 2 in the report, we say very clearly that, so far, workforce planning has not been effective. The reason for the report—and for its tone—is that that is key to the health service's being able to meet the needs of people right across Scotland in the years ahead.

10:00

Monica Lennon: Are you satisfied that the three-stage workforce plan that the Scottish Government will produce over the next year will be sufficient to address those problems?

Caroline Gardner: We think that the overall approach is a sound one. As members across the committee have hinted, there is still a lot to do, and the track record has not been encouraging, so we are watching progress closely. I am sure that the committee will want to explore that with colleagues from the Scottish Government.

Monica Lennon: Exhibit 2 in the report is about workforce pressures in the NHS and includes staff survey statistics on that issue. What will the consequences be if the workforce plan does not meet expectations on demand?

Richard Robinson: We set out some trends in exhibit 2. We considered issues such as how staff feel about working in the NHS because we want that to be as positive as possible, as does everyone else.

On specific levels, we highlight in part 3 of the report some of the potential scenarios that could arise if issues with the nursing workforce are not dealt with over the next few years, and how that could affect matters such as vacancies. As the report demonstrates—and as the conversations here today have done—a lot of factors are linked, such as vacancies, the use of agency staff and staff morale. Those are potential reasons for those pressures being important, which is why we think that workforce planning and its improvement are urgently needed.

Monica Lennon: The statistic that jumps out for me from the 2015 staff survey in exhibit 2 is that only one third of staff feel that there are enough staff for them to do their job properly, which is quite concerning.

Other committee members have touched briefly on allied health professionals, and I want to pick up on that area, too. I am interested in the fact that it is not the Government that sets the numbers of university places for AHPs. Do you think that that has to change?

Richard Robinson: In part 1 of the national workforce plan, the Scottish Government has said that it will explore that. "AHPs" is an umbrella term for a number of smaller groups, which means that the challenges around controlling the numbers of AHPs are different from the challenges around controlling the numbers in the larger nursing workforce. Further, AHPs frequently work across the NHS and social care—for example, some work in local government—so there are some complications around achieving a straightforward control number.

In our report, we make clear that AHPs have a role in that skills mix, and we highlight some areas, such as radiography. There are also shortages in certain areas of the AHP workforce, and it is for the Scottish Government to consider what the best skills mix to address that is, alongside the future demand, and then to ensure that it is getting the right numbers through the system, however that is decided.

Monica Lennon: We expect that, in the next five to 10 years, the nurse and doctor workforce will begin to grow. What impact will that have on AHPs?

Richard Robinson: I do not know the answer to that question, I am afraid.

Monica Lennon: I am just wondering whether, if we are moving towards a community-based model of care with more doctors and nurses to make referrals, we are keeping up as regards the supply of AHPs, and what that means for patient care.

Richard Robinson: I understand the question now. In the report, we make a point about recruitment and how what is done on medical, nursing and AHP posts is sometimes a bit linear. That fits in with what you are asking about, because the question is around multidisciplinary working, how those skills groups are going to come together and what the effect of an increase in the numbers of one group will be on the other. If the decision-making processes in some recruitment decisions do not have that joined-up view around considering the skills mix, that is a risk. That is why it is important to consider not only demand but how different groups of people will work together.

Monica Lennon: Given the challenges that we have heard about—for example, you mentioned that AHPs work in a number of different professions—how realistic an expectation is it that we can reach a point at which there is a holistic approach that captures all of that? Is it just too difficult?

Caroline Gardner: In a sense, it is essential. It will be difficult, partly because of the current lack of data and partly because, as Richard Robinson said, AHPs work in a range of different professions and settings. Occupational therapists, physiotherapists and speech therapists can play a huge part in the 2020 vision for keeping people at home as long as possible by assessing people's needs, helping to put in place the sort of support that keeps them at home and getting them home safely after they have been in hospital. Those professionals are often the people who can make a difference.

That is why it is key that we focus not just on the absolute numbers, but, as you say, on the mix of professions and the way in which they work together. You are right to say that the situation is complex, not least because a different mix of people will be needed in different parts of Scotland. What can be done in a city such as Edinburgh is very different from what can be done in a remote part of the Highlands. It is necessary to have a local picture and to build that up into the national picture in order to plan for the number of people who need to go through training to give the NHS a fighting chance of having in place the right staff to deliver health and social care quite differently in future.

Bill Bowman (North East Scotland) (Con): We have already touched on a number of topics, so excuse me if I repeat any of the questions.

The second key message in the Audit Scotland report refers to "confused" responsibility for planning. I would probably have had that as the first key message. I was going to ask whether the confusion is mostly around the legal structure and/or the operational working of the plan, but you said that it is not the legal structure. Monica Lennon asked whether there were any quick hits to reduce the confusion. In my view, we need demonstrable leadership from the Government to deal with the situation.

You say in the second key message that the Scottish Government is talking about

"setting up a National Workforce Planning Group".

That does not fill me with confidence. As you mentioned, an agency working group was set up two years ago, but in spite of that the costs of agency staff have spiralled since then.

I will ask a question that has not been covered so far. You talk about workforce planning in a trust, but what does that actually look like on the ground? Is there somebody in a room with a spreadsheet? Is there a specific department for workforce planning, or does part of another department deal with that aspect?

The term "supply chain for doctors" was used earlier. When we think of supply chains, we think of purchasing and payments, and a well-ordered process with checks and balances and controls. How would you compare workforce planning in that context?

Caroline Gardner: I will ask Richard Robinson to talk you through how local workforce planning works. First, for the record, it is important that I make it clear that, since the MASNet system came in a couple of years ago, we have seen a slight dip in agency costs. We have seen a significant rise in the past seven years, but there has been a slight dip lately, on which we are keeping a close eye.

Richard Robinson: As you would expect, arrangements will vary between NHS boards—

Bill Bowman: Should we expect that?

Richard Robinson: Some of the issues that boards in rural areas deal with will be different from issues in other areas.

Bill Bowman: What about processes?

Richard Robinson: With regard to processes, each board has a human resources director who is ultimately responsible for pulling together the workforce plans. That will involve conversations with medical directors in hospitals, for example.

As the report mentions, there is on the ground a suite of nursing workforce planning tools, including day-to-day tools to plan for the skills that are required on a particular day. Within NHS boards, there will be work at a variety of levels, ranging from the use of operational tools to assess what type of skills and workforce are needed on a particular day to HR directors making decisions on what the workforce plan for a hospital will look like.

Bill Bowman: You are talking about the sort of day-to-day management that determines who goes where. Is that different from the work of pulling together the plan and feeding it into the Scottish Government, which will presumably aggregate it in some way?

Richard Robinson: That will be done by the HR director—I am sorry for not clarifying that.

Bill Bowman: Are the data presented in different forms, or is there a standard format for reporting to the Scottish Government?

Richard Robinson: The workforce plans will be put into the format shown in exhibit 6. They will be set out as six steps, including defining what boards are trying to achieve, mapping their service change, defining their required workforce, understanding their workforce availability and so on. Each workforce plan will look slightly different but will be based around the six steps, as per the current workforce planning guidance, which will be refreshed.

Bill Bowman: Is it as simple as that, or is there more detail? You talk about steps.

Richard Robinson: One of the issues that we raise in the report is that we can see quite a lot of detail within those steps. Some of the workforce plans talk about the board's understanding of its workforce, the demographic challenges that it faces or the make-up of the issues that it is dealing with.

Bill Bowman: Do the trusts have any control over the information that is in a workforce plan? Is it checked internally?

Richard Robinson: I expect that it would be checked internally. The plans that we have looked at have gone through the board. Beyond that, I am not sure.

Bill Bowman: Does that mean that you do not know whether people have done internal checks on the numbers to see that they have captured all the information that they need, and that it is in the right format and all adds up?

Caroline Gardner: Based on the annual audit work, our impression—it is an impression, because we did not audit it in detail—is that establishment totals are an important part of the boards' financial controls, and that the data itself will be good enough for that purpose. Our concerns are more those that are set out on pages 20 and 21 of the report: first, that boards are looking only a very short period ahead; and,

secondly, that, because of the link to affordability, boards tend to underestimate their future requirement for staff.

In paragraph 34 of the report, we pull out some specific examples of gaps where individual boards have not fulfilled the requirements placed on them. More generally, we have those two concerns about the individual plans that boards are producing.

Bill Bowman: Some boards have services that are provided by other boards. Is that dealt with in the same way on both sides?

Caroline Gardner: It should be picked up in the step set out in exhibit 6 about boards being clear about what services they are planning for. However, one of the points that we make about the new elective centres and the integration authorities is that that approach runs the risk that either things will be covered in more than one plan or they will not be covered in anybody's plan.

Bill Bowman: Someone asked earlier how these points will be followed up and whether we should have another report from the NHS. I would have hoped that the Scottish Government would have some internal means of checking. Presumably, organisations would not like to get such comments from Audit Scotland, and someone would be keen to see that they were dealt with. Is anything like that happening?

Caroline Gardner: We would hope that it was happening, but our experience is variable.

The Acting Convener: There you go.

I want to finish up by clarifying a couple of things. It is the case that, ultimately, the Scottish Government determines the number of places that it requires for doctors and nurses and instructs the Scottish Further and Higher Education Funding Council accordingly.

Caroline Gardner: Yes.

The Acting Convener: I just wanted to be clear on that.

By any measure, the Scottish Government has not been terribly good at workforce planning in the past. Obviously, we hope that workforce planning will improve, but decisions in the past will have had an impact. Decisions made five, six or seven years ago are potentially coming home to roost now. Is that a fair comment?

Caroline Gardner: You are absolutely right in principle that decisions that we are making now will affect the number of nurses available in three or four years' time and the number of doctors available in 10 years' time. We have some data in the report—the team will help me point you towards that—on the impact of decisions about nursing training. Exhibit 13 sets out the experience of nursing training over the past few years, where we have seen exactly that knock-on effect on the number of staff available to join the nursing workforce.

The Acting Convener: I remember a period five, six or even seven years ago when health ministers took decisions to cut the number of training places for doctors and nurses. There was a bit of an outcry at the time. Decisions taken way back then, possibly on the basis of evidence that was not very useful, are coming home to roost now.

I am therefore very aware that workforce planning is a long-term issue. However, you have described symptoms such as increasing agency staff costs and increasing numbers of vacancies, which tell us that workforce planning is critical. Are you aware of any urgent measures that the Government is taking to address the situation? For example, are there return-to-practice courses? Are people who are about to retire offered flexible working to try to encourage them not to retire so soon? What measures are in place? There is a sense of urgency about this.

10:15

Caroline Gardner: We highlight in paragraph 84 a couple of initiatives that the Government has under way. First, there are additional nursing and midwifery training places to address the likely shortfall. We welcome that but, as I said in my opening statement, we think that there is a risk that it is not sufficient to fill the gap, depending on the retirement patterns over the next few years. Secondly, the Government is increasing funding for return-to-practice schemes. Again, that is a helpful measure, although it is a short-term measure initially. We are keen to see more of those measures to fill the gaps that we see around Scotland; moving upstream, we are also keen to see measures to ensure that workforce planning itself is more comprehensive and more sustainable for the future.

The Acting Convener: We have considered the financial risks and things that need to happen. Have you assessed the patient risk? I ask because I am very conscious—my constituency postbag tells me this—that the waiting list guarantees are out the window for services from orthopaedics through to cancer services. We are just not coping with the number of patients who are presenting. Is a lack of workforce planning putting patients at risk?

Caroline Gardner: That is obviously the most important question. We looked to see whether we could find correlations between the pressures on staffing and patient experience, staff experience and the old health improvement, efficiency, access

and treatment—HEAT—targets. It is fair to say that in most cases we did not see a direct correlation. In paragraph 18, for example, we talk about performance against the eight performance targets that are set for the NHS in Scotland. The NHS as a whole did not reach seven of those last year, but we found no correlation between boards with higher vacancy rates and other signs of pressure.

We also looked closely at the reports from the Care Inspectorate and Healthcare Improvement Scotland for any indications of problems in the quality of the healthcare that is being delivered that they linked back to staffing shortages or other staffing problems. We found a couple of relatively tenuous links but, again, not in that direct sense. What we are probably seeing is staff working harder and harder to keep the service running, as we all recognise that health service staff do day in, day out. That is to be hugely commended, but it is not a strategy for the longer term. That is why that longer-term investment in planning and understanding what staff we need and then developing them for the future is so important.

The Acting Convener: I invite you to look further at that issue in a future piece of work; we will certainly raise it with the Scottish Government when it is before the committee. I can share with you that in NHS Greater Glasgow and Clyde, the waiting time for orthopaedic treatment is over 52 weeks, which is directly linked to staff shortages. Although the Government has given money, the board is employing a locum, so we are perpetuating the problem. People are not getting treated, which has individual consequences.

Caroline Gardner: We recognise that that is the case at a local level for individual specialties or particularly rural boards and we will keep a very close eye on it.

Alex Neil: Many years ago, medics and others working in rural areas were paid a differential salary. I think that that was scrubbed as a result of the 1994 negotiations. Clearly, rural Scotland has a very high percentage of the long-term vacancies and shortages. Is there a case for looking at returning to a differential so that there is an additional incentive for doctors, nurses and others to work in rural areas?

Caroline Gardner: There is a case for considering it but, as always, I would caution that starting with the data is the most important thing. Exhibit 8 in our report shows clearly that some of the boards with the highest vacancy rates are rural boards. However, the board at the other end of the spectrum is NHS Orkney. There are different things going on in different parts of the country. Rurality is undoubtedly an issue, but the analysis needs to take a more nuanced approach, and so does the response.

Alex Neil: But it should be considered.

Caroline Gardner: Absolutely.

The Acting Convener: Thank you very much for your evidence this morning. The committee will now go into private session.

10:19

Meeting continued in private until 10:33.

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