OFFICIAL REPORT
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Public Audit and Post-legislative Scrutiny Committee

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Thursday 9 November 2017

CONTENTS

	Col.
DECISION ON TAKING BUSINESS IN PRIVATE	1
"NHS WORKFORCE PLANNING"	2

PUBLIC AUDIT AND POST-LEGISLATIVE SCRUTINY COMMITTEE
26th 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:

Dr Catherine Calderwood (Scottish Government)
Paul Gray (Scottish Government)
Shirley Rogers (Scottish Government)

CLERK TO THE COMMITTEE

Terry Shevlin

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Public Audit and Post-legislative Scrutiny Committee

Thursday 9 November 2017

[The Acting Convener opened the meeting at 09:01]

Decision on Taking Business in Private

The Acting Convener (Jackie Baillie): Good morning and welcome to the 26th meeting of the Public Audit and Post-legislative Scrutiny Committee in 2017. I ask everybody in the public gallery to switch off their electronic devices, or at least to switch them to silent mode, so that they do not interfere with the work of the committee.

Item 1 is a decision on taking business in private. Do we agree to take item 3 in private?

Members *indicated agreement.*

"NHS workforce planning"

09:02

The Acting Convener: Item 2 is evidence on the Auditor General's report "NHS workforce planning".

I welcome to the committee Paul Gray, the director general for health and social care and the chief executive of NHS Scotland; Shirley Rogers, the director of health workforce and strategic change; and Catherine Calderwood, the chief medical officer, all of whom are from the Scottish Government. I invite Paul Gray to make an opening statement.

Paul Gray (Scottish Government): Thank you, convener. I am grateful for the opportunity to present evidence today. I trust that the questions will be shared appropriately between me and my colleagues. If there is anything to which we do not have a factual answer, we will seek to provide it as quickly as we can. If there are any issues on which we require to take further advice from other professionals, we will do that and provide the evidence to the committee as quickly as we can. I do not want to take up the committee's time with a long speech, so I am happy to hand over to you for questioning.

The Acting Convener: Thank you very much, Mr Gray. Last week, when I was not here, unfortunately, the committee heard from some of the witnesses that there appears to be no coherent plan in place. If you were to gauge the importance of having a coherent plan, would it be something that you would regard as nice to have or absolutely essential?

Paul Gray: There is a coherent plan, and we have already published phase 1 of part 1 of that plan. There are two parts still to come, one of which is already well forward in preparation and the other of which is on the stocks. Is it nice to have or is it essential? It is essential. That is why we are doing it. We would not be doing it if we did not think that it was essential. In the present context in which we operate, focusing on the essentials is important.

The Acting Convener: Workforce planning decisions were made before, when previous ministers took decisions to cut or, indeed, increase numbers. On what basis did they make those decisions if we are only now arriving at a comprehensive plan?

Paul Gray: I will ask Shirley Rogers to come in on that in a moment. Ministers in different contexts or in different Administrations would make their decisions on the basis of the best advice that they had at the time and in the context in which it was

given. A decision that was made five, 10 or 15 years ago would have been different from one that might be made now, as there have been significant changes over time.

I offer three areas as examples of that, although they are not meant to be exhaustive. First, in clinical practice, things are now done differently from how they were done five, 10 or 15 years ago. Secondly, there have been changes in our approach to multidisciplinary teams, so the spread of work across different disciplines is different and we need to plan for that. Thirdly—I genuinely do not want to pull us off on to this—contextual issues such as Brexit and the decisions that are made around that have an impact on how we might plan for a future workforce if our stock of people is likely to come from different sources. We apply all those considerations and many others when decisions are made.

The Acting Convener: If you had such good planning tools and such a positive approach to planning in the past, why do we have such acute shortages? Given that it takes 15 years to train a consultant, surely we should be horizon scanning in a way that allows for that, not thinking simply in five-year bursts.

Paul Gray: Your point about thinking not just for the medium term but for the long term is fair. We have seen changes in how clinical practice is delivered, but it is also a fact that, in some specialties there are worldwide shortages. The chief medical officer could speak to that. We are up against the same situations that health systems in other developed countries face. I say that not as an excuse; nonetheless, it is a fact that, in some specialties, it is difficult to recruit beyond national boundaries and internationally.

I also think that, having developed a comprehensive workforce plan, we are drawing together significant strands of work that have always been done. We are not inventing some great newness here; we are bringing coherence to work that was always done, perhaps, on a narrower basis, and that is all to the good.

The inclusion of the social care workforce in the plan is another important contextual difference from what might have been done in the past. We are working closely with the Convention of Scottish Local Authorities, the Society of Local Authority Chief Executives and other partners to make sure that we get that aspect of it right.

I do not know whether you want either the chief medical officer or the director of workforce and strategy to say more about either of those issues.

The Acting Convener: We will probably pick them up in questioning from other members.

Colin Beattie (Midlothian North and Musselburgh) (SNP): For how long have you been working on a national workforce plan?

Paul Gray: I will ask Shirley Rogers to give you the detail of that. We have been working on what we have now produced for at least a year. I am happy to help you further if there is a more specific point that I can follow up on.

Colin Beattie: The plan should not be something new. I presume that you have been working with the different boards on a national plan for some years. However, I am looking at the evidence that you have submitted to the committee and I am struggling to see anything other than jam tomorrow. There is nothing firm in there. It is all things that are “under way”, “under active consultation” or “being considered”, and you say that you are going to re-circulate guidance. There is nothing firm there.

Paul Gray: There are approximately 156,000 people working in the national health service in Scotland at the moment, and they came from somewhere. They came from the planning that we did, and they are still coming from the planning that we did. If we had had no plan, there would be no people. Universities do not train people on the basis of speculation that something might happen.

I accept that what we are doing is drawing together strands of work that we have always done, but I do not accept that it is all jam tomorrow. There are doctors, nurses, physiotherapists, pharmacists and allied health professionals working in the NHS in Scotland today because of the planning that we did.

Colin Beattie: You say that you are drawing together threads that already exist and that are already giving you the information that is necessary for a national workforce plan—is that correct?

Paul Gray: We are doing that, and we are augmenting it through further work that we are doing on data, for example. I know that the committee took evidence about data, and that is an area in which we know that we have data. We have substantial amounts of data, but we need to improve the way in which we draw that together, co-ordinate it and present it, so that there is an improvement in both the quality of the data and the transparency with which we present it. We are looking to improve. I am not disputing that there are things that can be improved; I am saying that we are improving on the basis of work that we have already done. Shirley Rogers may want to give you more detail on that.

Colin Beattie: Last week, we received evidence from four NHS boards, which gave us a joint submission that was pretty negative about how that is going to work. It states:

> "How this will be done is not yet clear but it is believed that the new National Workforce Planning Group will provide leadership on how this will be done."

They do not seem to have a terribly upbeat idea as to how it is all going to come together. I realise that it is a complex matter but, if those very highly paid guys who are running the boards do not know how to do it, how is it going to work?

Paul Gray: I will bring in Shirley Rogers in a second. Because we have made a determination to consult on the different chapters or phases of the plan as we have gone along, we are currently consulting on the second part. We are working with COSLA, SOLACE and others, as I have said.

If I were to ask any chief executive, "How will part 2 of this work exactly?" the answer inevitably would be that they cannot know in full, because it is not here yet. You cannot know how something is going to work before it is here. My view is that we have the necessary governance and consultation in place. If the feedback from chief executives is that they would like more clarity on how it is going to work, we would be very happy to provide that.

I am slightly concerned that senior chief executives are giving the impression that they do not do workforce planning. They do. I know those individuals, and they do workforce planning.

Colin Beattie: No—they did not give the impression that they were not doing workforce planning; they said that they did not see how it was all going to be brought together across the whole of the NHS. What I took from their evidence was that workforce planning is taking place within the different disciplines but those four boards do not know how you are going to pull all that together at a national level to have a coherent national plan. They say:

> "Boards plan using a 'bottom up' workforce planning approach. Extending this to involve partners across health and social care will provide a more considered workforce plan."

However, they say there are different tiers and that they do not know how it is going to be done. Is the national workforce planning group going to provide the leadership guidance that is going to take the matter forward, as they believe it is? If so, how?

Paul Gray: Indeed. I invite Ms Rogers to give you the details of how that is going to happen.

Shirley Rogers (Scottish Government): I joined the NHS in Scotland nearly 22 years ago, and we have been workforce planning for at least as long as that—probably longer. Over the last wee while, where the workforce planning methodologies have been put in place, we have been attempting to give boards and all the other agencies that are required to come together to develop the plan one simple methodology. If I cast the clock back to my early days in NHS Scotland, we probably did that by speciality, and we certainly did it by board. The committee will understand that, as we evolve our workforce planning approach, those things are not going to cut the mustard going forward, and they have not been doing so for a little while.

We have put in place a six-step workforce planning methodology across NHS Scotland, and we have been working with colleagues across the wider public services that are involved in the delivery of healthcare to share that methodology in order to have the same approach and to know how to count the same things. An indication of the breadth and complexity of that work is the fact that part 1 of the workforce planning involved consultation with 79 different stakeholder organisations. It is terribly important that we share that methodology and give that leadership through the workforce planning group, so that we are all doing the same kind of thing and we are all modelling, scenario planning assumptions and all the rest of it on the basis of that.

09:15

The national workforce plan is different for three reasons, only one of which is about its being national. The ambition of the workforce plan was to do three things. The first ambition was to bring workforce planning into a national picture, which we have done through stage 1 and will continue to do in rolling out our methodology.

The second ambition was to look at workforce planning from the perspective of its being multi-professional. For example, it is fine and dandy to have enough surgeons, but, if we do not have enough anaesthetists, that is no good. If we do not have enough theatre staff, we can have as many anaesthetists and surgeons as we like but that is no good. The same applies to porters, cleaners and all the other people who make up the health service.

The plan is an attempt to do workforce planning in a multi-professional way that allows us to plan for scenarios involving emerging professions. For example, 22 years ago, the number of paramedics in Scotland was quite small in comparison to the number that we have now. We have seen similar growth in things like emergency medicine and intensive care, where we have seen professions emerge that require different relationships and different teams to make those services work. The second ambition of the plan was to look at the health service from the perspective of how teams need to be planned to work together to deliver services in a multi-professional way. I believe that it is starting to achieve that ambition, and I can give some evidence of that if that would be helpful.

The third ambition was to increasingly recognise that the health of the population is not delivered simply by the NHS. In order to support people to be healthy and to live at home, we need a range of agencies. The third ambition that makes the plan different is to ensure that we look not just at health in the traditional sense but at all the services that supply, support and help people to live at home or get back into their homes once they have emerged from hospital.

There are some other things that make the plan a little bit different. For the first time, we are not only comprehensively considering the established workforce but spending a good deal more time in developing our understanding of the workforce in training. Convener, you observed the long-term nature of medical training, and it is important that we understand what our supply pipeline looks like. It is really important that we understand not just the numbers involved but the reasons why people make decisions. What is a student entering medical school going to come out with at the other end, bearing in mind the long-term nature of foundation and specialty training?

The ambition of the plan—we have already started to see the evidence of it—will allow us to look not just at the existing workforce but at those people who are coming through training and what their choices are. It is about not just whether they decide to stay and practise medicine in Scotland but how they choose their specialties and how we can make the specialties that we require more attractive in order to attract the numbers that we need.

I will add a final thought—forgive me for giving a somewhat full answer, but we can come back to any of the issues. The other thing that the workforce plan has allowed us to do is look at the training ratios that we deploy in Scotland. Twenty years ago, if we needed a general practitioner we trained a GP. That is no longer good enough, because people now make choices about how they want to work. They will not necessarily want to work full time, and they will not necessarily want to stay in the same specialty for their whole career. We are now in a position where we can nuance the training ratios. Indeed, in general practice, we are now training two GPs for every one that we think we are going to need, to allow us to be sensitive to such issues. Our ratios are not 1:1 across the piece; we have 1:4 ratios and 1:6 ratios depending on the specialties and the shortages that we expect to have.

The process is not finished yet. I am not going to sit here and say that we have everything that we will ever need, but we are a lot more mature now than we were, and we have the foundation blocks in place that will allow us to use the same methodology across the piece so that we at least understand the things that we are trying to move forward.

Colin Beattie: What you are saying sounds good, but the joint submission from the four boards makes it seem much more a raw work in progress, with not a lot done yet to pull things together. There seems to be a gulf between the confidence with which you are putting forward what seem to be logical ideas and what seems to be the consideration on the ground.

I will ask one other question on that particular piece. The joint submission says:

"Work is underway to try and bring key workforce data together into a single platform."

What is the cost of that? A single platform to me suggests a major IT project and bringing together lots of different systems that are going to feed information into it. Is that the case? Is there a budget and a timescale for that work? How is it being managed?

Shirley Rogers: I am not surprised that the chief executives who gave evidence last week could identify a greater degree of maturity in some of the systems than in others. Some of the issues to do with workforce planning across social care provision involve a great many organisations, not all of which are statutory partners. Getting the methodology in place is not instant. We are talking about some organisations that are very large, and some that are much smaller; some that have specialist workforce planners, and some that do not. Sharing that methodology is a journey, and I am not going to pretend that it is not.

In response to your specific question about the cost of the platform, I will give a little bit of an explanation. People will understand that there are a number of ways in which people enter the health workforce. They will do so through medical training banks, General Medical Council registers, Nursing and Midwifery Council registers, midwifery training—a raft of different things. Some of those have different systems that have been built historically to achieve those things. We will generate efficiencies from taking all the information that is currently held in a plethora of different places, bringing that together and probably running the vast majority of it through NHS Education for Scotland and some of its established platforms.

The reason why we are able to do that harks back to the point that I was making about starting workforce planning with people entering medical education and nursing education and building the platform from there. We have made some inroads into that already. We are using the Turas platform that NES has developed to do some of that for us, and we are getting the Information Services Division, the analytical services division and lots of

other agencies working together to share data in a way that gives us a central place. Using that central platform allows us to model.

Colin Beattie: Why has all that not been done before?

Paul Gray: Because we are changing the way we are doing workforce planning. NHS England has just announced that it is about to have a national workforce plan, which I am pleased to see. We are moving from a board-based approach to a properly nationally based approach. That is consistent with our approach as set out in the delivery plan that was published in December 2016, in which we are very clear about what is being done nationally, regionally, locally and in communities at an individual level. This is consistent with the direction of travel that we have adopted.

Colin Beattie: What you are saying is very significant. You are moving from board-based to nationally based workforce planning. Does that mean that workforce planning is going to be centralised and taken away from the boards?

Paul Gray: No, it does not. Shirley Rogers can say more about that.

Shirley Rogers: Some aspects of workforce planning have a national dynamic to them. For example, we will always take a national view on the number of people entering medical school. We will also look at the number of people entering a particular specialty from a national perspective, sometimes because those specialties have very large numbers and sometimes because they have very small numbers and it would not do for each board to act individually in that space.

I go back to the point that I was making earlier about the team dynamic. I suspect that we are unlikely ever to do national workforce planning for administrative support in local board offices, but the notion of workforce planning always being done locally is probably not sustainable for those key, critical professional groups that have funding arrangements for their long-term education, such as nursing, midwifery, medicine, various allied health professions and medical sciences.

We need to do some things nationally. For example, the work that we have been doing to widen access to medical skills could never have been done on a board-by-board basis; it needed a Scotland-wide approach to be able to do that. However, it would be wrong for us to conclude that there will be no activity at board level, because there are some jobs whose nature is such that they need to be workforce planned at local level. Also, remember that workforce planning is part of a triangulation between service planning, financial planning and workforce planning, so local decisions around where services happen will also be a big influence on the workforce plan.

Liam Kerr (North East Scotland) (Con): I would like to direct a question to Mr Gray. You have two roles, Mr Gray. You are NHS chief executive and director general in the Scottish Government. I put the question to the boards last week. How do you perform those two roles in relation to the boards? Are you directive—do you tell them how they will work?—or are you much more consensual and collaborative?

Paul Gray: I have two roles, but I generally describe my job as having three, in fact. If I can start by telling you what those roles are, I will then answer your question.

I am a member of the Scottish Government's executive team, so I have a corporate responsibility with other director generals and the permanent secretary for the corporate performance of the Scottish Government as a Government department. As the director general for health and social care, I am the principal policy adviser to whoever is the cabinet secretary for health of whatever Administration. As chief executive of the NHS, I am responsible for delegating to the chief executives of the health boards authority and responsibility to perform the functions of those boards. I am the accountable officer for the health budget and I delegate to those who are accountable the authority and responsibility to carry out those things.

I am assuming you are not asking me about my management style and preference but rather about how the governance arrangements sit. The governance arrangements at the top level are that I have to satisfy myself that the accountable officer for a health board has the capability and capacity to carry out the functions in order to make a proper delegation to them, and I therefore require certain assurances annually about the delivery of what has been delegated. I have powers of intervention through the ladder of escalation that we have, which has five steps on it. The fourth step would involve direct intervention by me. The fifth step involves direct intervention by the cabinet secretary or minister, so I have a power of intervention.

It is always better to get people to agree to things than it is to impose them. For example, on the issue of junior doctors' hours, we reached a point at which I wrote to the chief executives of the health boards setting out what I expected. At the start of my tenure, there was considerable use of chief executive letters, which are letters of instruction. I have reduced the use of those considerably. I took that decision on the basis that, if you are continually instructing the health boards to do this, that and the other then, in effect you are removing from them a sense of responsibility for

doing it, so I use such letters very sparingly. I use them to delegate money and functions and matters that I think have reached the point where I have to deliver an executive decision but, generally, I would prefer to engage with health board chief executives, medical directors and nursing directors and others on the basis of reaching agreement about the best way to do things. Ultimately, though, I can and do decide.

09:30

Liam Kerr: Thank you. I will focus on the plan that Colin Beattie was exploring. When I asked the chief executives last week, "Are you telling me there is no plan?" the clear answer was, "There is no plan", which I found terribly concerning. I then asked one of the chief executives, "Well, who is responsible? Who has failed here?" and the answer that I got was:

> "All of us—from health board to Government—have failed to pull together the link between short-term operational delivery and longer-term workforce planning." —[*Official Report, Public Audit and Post-legislative Scrutiny Committee*, 2 November 2017; c 13.]

Is that your view? Who has failed here, Mr Gray?

Paul Gray: No, it is not my view. I am perfectly clear that in all things I could always do better. I never take the view that I have reached some state of perfection when I could not improve. Out of respect to those who gave evidence, let me not seek to interpret what they said—what they said is what they said—but let me tell you what I believe to be the case. We have already published part 1 of our workforce plan, and we are developing parts 2 and 3. That does not seem to me like failure. It is perfectly legitimate for the committee and other commentators to say what they think of the plan—I would not object to that and it would be entirely proper—but it is simply inaccurate to say that we have failed to produce one. There is one, and it is visible.

Liam Kerr: I will stop you there, because that is very much about what is happening now, and I will explore that in a second. What I am interested in is the fact that Shirley Rogers has said that workforce planning has been going on for 22 years, yet we are sitting here today with a significant hole in the workforce—I used the word "crisis" last week—which has not been planned for, it would appear. Who has failed to plan?

Paul Gray: Nobody has failed to plan—I know that it is easy for me to sit here and say that, Mr Kerr, and I do not regard your question as unfair. We are where we are because of, as I said in response to the convener, changes in context, changes in demand and changes in the way we do things. Ministers have reached the conclusion—rightly, I think—that a national workforce plan is now necessary and that is what we are producing. If every time we produce something new, we describe the past as a failure, it will make it very hard to produce anything new—there will not be much motivation to do that.

Liam Kerr: Would you describe the past as a failure given where we sit now?

Paul Gray: No, I would not. Patient satisfaction with the NHS is at 90 per cent. To me, that is evidence of success, not failure.

Liam Kerr: I am slightly struggling with that given that we have significant workforce challenges in the north-east. I accept what you say about the delivery and I accept that the people are working very hard to ensure the level of delivery, but I cannot help but conclude that we are sitting with a depleted workforce because no one has planned the workforce in the past. Am I unfair in concluding that?

Paul Gray: It has never been my habit to describe committees as unfair and I will not do it now. I want to bring in Shirley Rogers in a second, but I will say this first. I was at a conference last week for general practitioners, which was run by *Pulse* magazine. It happens every year in Scotland and I was interviewed at it. I spoke to an audience of about 270 general practitioners, their support staff and some patients. I heard from a general practitioner that one of his colleagues, who is also a GP, had hurt her back and, because of concerns about workload and about her income, she was continuing to work even though she was writing sick notes, as he put it, for people who were no more unwell than she was. In other words, she was working in a condition for which she was signing other people off.

I am not complacent about this. That is not how things should be. In some areas in general practice it is close to impossible to recruit. I accept that as a fact. I am not pretending that it does not exist. I know that in the Highlands—and the chief medical officer has been there recently and can say more as required—they are struggling to recruit into radiology. I accept that.

However, if we describe that all as a failure of planning, that means that the whole world has failed to plan, because there are recruitment pressures in every health system in the developed world. The pressures are probably worse in the third world. We are sending people to help in other countries where they have no supply at all.

I am not sitting here saying that there is some state of perfection in Scotland. There is not, but that is why we are doing what we are doing. I hesitate over conceptualising it as failure. The example that I would give is this. In 2014—

Liam Kerr: Mr Gray, if you do not mind, I think that it is perhaps more important that we project

forward now. To use words that I think have been used earlier, we are where we are. You are now trying to get a handle on it and are looking forward. I asked last week what happens if we are still sitting here in three years. Who owns this process? Who has the ball and who will be sitting here in three years if it does not work?

Paul Gray: I am the accountable officer. I have the ball and I am happy to sit here. I hope that I will be sitting here in three years because I believe that I will have something good to give account of. I am supported by the director for workforce and strategy, the chief medical officer and many others in delivering this but, ultimately, I have the ball and I have never failed to accept that.

Liam Kerr: Thank you. I appreciate the clear answer. I have two brief questions on a slightly different tack but the same sort of thing. We are obviously all very concerned about the future, and it is good to hear that you are intending to get it sorted. What are the practical consequences, in your view, for both the staff and the patients? The Auditor General refers to urgent workforce challenges. If those are not addressed and what you are doing does not work, what are the consequences?

Paul Gray: I think that the consequences would be bad. May I make use of my colleagues and bring them in, because I would like to draw on the senior expertise that I have here? Perhaps Shirley Rogers and then Catherine Calderwood could say something about what we are doing. I think that we should particularly focus on Mr Kerr's question about what we are doing and what consequences we are seeking to avoid.

Shirley Rogers: I would be the first to recognise that there are some challenging recruitment circumstances across various parts of Scotland and you are right to identify some of the issues to do with rurality, for example, and GP populations and so on.

Just to put some sense of our continued effort into that space, I have been very proud to work for the NHS for 22 years. It is something that is very important to me, and we are not going to sit on our laurels and say, "Haven't we done well?" when we know that there are big challenges ahead. Let us face those challenges.

We currently have a 96 per cent fill rate for our specialty training posts for medicine in Scotland. That is extraordinary. Within that 96 per cent there are some great successes, but there are also some challenging areas, and we know that. Our efforts are around widening access into medical schools, increasing the numbers going into nurse training and various other things that will try to improve on that.

There are some successes to point to. I can point to the track record of emergency medicine, which I mentioned earlier, where we are seeing a 192 per cent increase in the establishment from 2006 to 2017. We know that we can do this stuff. There has been similar growth in the paramedic communities. We are looking at different models of how we provide care that mean that people, wherever they live in Scotland, whatever their healthcare needs, get what is appropriate to them.

We are also working hard on how people feel working for the NHS. As the director of workforce, I do not spend my time just doing workforce planning. We also spend a lot of time looking at employee engagement, how people are feeling and how we support people in the workplace. At certain times it can be quite difficult and I recognise that.

There is a lot of activity going on right now to improve the supply of our workforce and to look for different models—for example, the use of physician associates, who are being used to great effect in Grampian to address some of the issues there. We are looking at whether there is greater scope to roll out those kinds of initiatives. We will continue to focus on rurality. You may have seen that there was an award made to the University of Aberdeen yesterday for the exposure that it is giving its medical students to rurality. We have been working very hard in the area of rural practice to try to make sure that people who work in rural Scotland feel supported and have good, appropriate educational links. We know that the ability to recruit into rural Scotland is enhanced when people feel that there is an opportunity to continue to develop their clinical practice through academic links and so on.

Liam Kerr: Forgive me—I am aware that my colleagues wish to come in—but I have just one question on recruitment specifically. The Auditor General notes a 6.3 per cent increase in overall NHS staff levels since 2012 and, at about the same time, an 11 per cent real-terms increase in staff costs. The report goes on to suggest that there is not always a clear link between staff shortages and the outputs in service delivery. Has there been a formal assessment of the relationship between increasing staff levels and staff costs, and the outcomes delivered by the NHS?

Shirley Rogers: It is a very fair question and it is fair to say that one of the things that we are working on now is that notion of productivity and outcome. You will have seen some of the reports that were published yesterday, in which the BBC was commenting on that dimension in England. There is work starting there to look at that very same issue. Put bluntly, do the growth and the growth in cost generate a commensurate improvement in health? For certain things, we

have the foothills of some evidence that would suggest that there is a relationship. For other things, there is still a sense that greater efficiencies can be made in the way people work together in providing appropriate community solutions, for example; an investment in community staff might bring an overall improvement on our financial position because people are not being admitted to hospital.

The short answer to your question is that I do not have it yet. The longer answer to your question is that we are on it and we will have it over the next wee while.

Liam Kerr: Thank you.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): Could I start off on what I hope is a positive note? We know that there are more staff in the NHS: more doctors, more nurses and more consultants; indeed, there are nearly 3,000 more GPs in the service than there were, say, 10 years ago. Public satisfaction, which Mr Gray mentioned, is very high, and the NHS in Scotland is highly regarded. It also seems to be performing the best of all the United Kingdom NHS services—I put that on the record; it is a very strong positive. However, there are many issues that face the service, as we all know.

I am interested to get the panel's views on the bigger picture—on service redesign and what that might look like over the next few years. We know that there are pressures on GP practices, influenced by the pensions' issue, early retirements and so on; we know that the accident and emergency service, although performing well, is under pressure; and we know that agency and locum costs and so on are spiralling. What are we doing in those three key areas, in which the public would expect to see some progress in the next few years, to try to manage and improve those aspects of the service?

09:45

Paul Gray: You are asking me about service redesign, pressure on staffing—you mentioned A and E and general practice—and agency and locum costs. Those are the three things to cover.

I might ask the chief medical officer to say something about clinical staffing and what we are doing about that, and I will say a little about service redesign. I will ask Shirley Rogers to pick that up further in the context of transformation—Shirley chairs the transformation delivery board—and she will give further detail on locum costs.

On service redesign, let us have in our minds, first of all, that we are already implementing the legislation that paved the way for the integration of health and social care—we are already doing that. It would be fair to say that it is more advanced in some places than others—I would be the first to say that—but there are some successes to draw on.

The reason I spoke earlier about looking at what we do nationally, regionally, locally in communities and individually is because our service redesign has to be coherent around that. I want to move the focus from hospitals and estate—in other words, a view of the health service that is largely informed by hospitals, practices and offices—and turn it right round so that it starts with the individual. I want the design of our services to be focused on more people living longer, healthier lives at home or in a homely setting, which remains our strategy.

Why the local, regional and national view matters so much is because if things are done in a patchy way, or if we are unclear or incoherent, we end up doing things either twice or not at all. In the south-west of Scotland, for example, as in all other areas, one of the things that we have to be ready to deal with over the weekends when there are fewer staff on duty is gastrointestinal bleeds. If that happens over a weekend in NHS Lanarkshire, NHS Ayrshire and Arran or NHS Dumfries and Galloway, there will be pressure on the number of doctors available to deal with it, so a regional solution makes sense; otherwise, if you recruited enough doctors, you would end up with most of them standing idle most of the time rather than dealing with the emergency, or still being short because one board has enough and the other two do not.

Therefore, the three chief executives have been working on designing a system that means that that service is provided regionally because that is not just the most efficient and cost-effective way of doing it but because it is the way that delivers the best service to patients. I will stick at just one example, but there could be many.

Service redesign needs to be focused on the patient, not on the provider; and the integration of health and social care is proceeding.

The other and last point that I will make before handing over to the chief medical officer is that engaging the public in service redesign is utterly fundamental. We can have the best service redesign in the world, but if the first time the public hear about it is when we close one thing and open another thing, we know very well what is going to happen as a result: we will do things that people do not like—although I rather hesitate to say it—not because they are bad, ill conceived or misjudged, but because if people are used to a service being delivered in a particular way, the prospect of change is hard. We have a responsibility to ensure that changes are properly understood and have proper clinical buy-in. We owe that to the public.

Dr Catherine Calderwood (Scottish Government): One of the issues about the pressures, particularly in A and E—if we start with that—is very well illustrated by Mr Beattie's and Mr Kerr's questioning about the past and then looking to the future. Mr Neil, who is a former cabinet secretary, will remember when the Royal College of Emergency Medicine came forward with a really difficult, challenging workforce crisis. At the time, what was happening—and this is where the complexity and also the dynamic change of how our service is run plays through—was that demand in A and E was increasing; people were doing traditional on-call rotas; consultants were available only for the most severe cases; and A and E was being used very differently from how it is used now—people were not signposted to other areas. Then we added a four-hour waiting-time target to what was a pressurised system, which, I think, led to the senior, decision-making part of the team, the consultants, saying, "There aren't enough of us." As Shirley Rogers has said, the consultant workforce almost doubled in a seven, eight or nine-year period.

Therefore, the system is changing according to the demands and the pressures on it, but the system needs to continue to change. There are examples across Scotland of places where the signposting in A and E is better, so there is much less demand, or there is more direct access via general practitioners, so that emergency medicine doctors are used only for emergency cases.

There are different ways of working. There could be a senior decision maker, triaging at the front door and preventing admissions. There are also areas of Scotland where there is a team at the front door who are able to discharge directly back to home—for a frail, elderly person who has perhaps fallen, they could see that they take a physiotherapist with them, and there will be an occupational therapist there to assess them. Traditionally, people would have come in and been admitted, which not only was not the right thing for them but increased the pressure on the system. Therefore, part of our plan is to look at these different ways of working, taking into account what we now know to be better ways of treating people that overall give better outcomes.

I will not assume but some of you may have read or heard of my report "Realistic Medicine", which talks about the fact that some of what we do overmedicalises and overtreats people. In fact, not only doctors but all healthcare professionals and the public are reacting by saying that they realise that people do not always have to see a doctor or be admitted and that there are alternatives. In fact, for the biggest group of conditions that GPs see, musculoskeletal conditions—accounting for about 40 per cent of GP workload—people often have a better outcome from seeing a physiotherapist; the GP is not necessarily the expert. In fact, orthopaedic surgeons tell me that with physiotherapy and rest, many of these conditions do not need any medical intervention.

While I absolutely agree that there are GP workforce pressures and that recruitment and retention are very difficult, we are responding to changing needs and looking for evidence of what will provide the best outcomes for people. The traditional model of the doctor doing something is no longer the right thing to do. Therefore, the issue in GP practice is not just about recruiting more GPs; it is about looking at the staff mix and considering who the right professional is for a problem in a much more systematic way.

The GPs welcome that. Recently, I have been to speak to groups of GPs. Obviously, they are under pressure, and what they tell me all the time is that they do not have enough time. What I would like to see is general practitioners, who are expert generalists with a medical degree, only seeing the people they are going to make a difference to and for whom, with their medical background, they are the right practitioner. What GPs tell me, though, is that that would mean that they would only get the difficult and complex patients and, sometimes, in a busy clinic, it is quite nice to have something that takes two minutes or five minutes and lets them catch up. Therefore, there are unintended consequences. However, what we must do is do the right thing for the people of Scotland.

Re-examination of our traditional way of treating people is fundamental to all of that, and so far, from the reaction to "Realistic Medicine", it seems that the public agree.

Shirley Rogers: I will pick up on the transformation aspects and then move on to your question about bank and agency costs.

Paul Gray has already talked about national, regional and local activity, and I wanted to pick up a few things that I think are really important in the work that we are taking forward around that. The whole thrust of our transformational strategy is to try to support individuals in communities to get what they need, where they need it and where it makes most sense for them. Some of the activities around regional activity—it is interesting that the chief executives who gave evidence to the committee on 2 November were all the regional leads for this work—are about doing things sensibly at a regional level that should be done at a regional level to allow those local things to get on with what they are doing and provide services. Some of that gives us an opportunity to try to reduce some of the harmful variation that we see and to roll out quickly and with some consistency some good practice, where we find it, on a larger platform.

There are some other things that we are thoughtful of. I was hearing some evidence yesterday about the fact that one in four of the cases treated by the Scottish Ambulance Service has a mental health dimension. That is something that I am not even sure was recorded 20 years ago. We are looking again at how we train people to deal with the reality of the cases and the complexity of the patients that they are now seeing. That is requiring us to go beyond the traditional boundaries and to look again at things such as mental health first aid. In fact, we were hearing yesterday about the—if I remember rightly—approximately 16,000 Police Scotland officers who have been given mental health awareness training. The landscape and the training are different.

We need to embrace technology. Some of the service transformation that is taking place will be invisible—where a radiology film is read, for example. Now, the technology exists to allow us to do that wherever and to use capacity. Increasingly, in the east of Scotland, you will see a relationship developing between NHS Fife, NHS Lothian and NHS Borders to use capacity there to be able to read radiology films, because it does not matter where you are to see the film with enhanced use of technology.

Finally, I have some thoughts around innovation, because if we are genuinely to make our best efforts to make the NHS sustainable going forward, there is a great deal of innovation that we need to promulgate. For example, I know of a consultant working in a district general hospital—she was a gynaecologist—who discovered that women who came to her, unless they were diagnosed with something very serious, seldom came back for their second appointment. She did the brave and unusual thing of ringing up her patients and saying, "Why not? Why aren't you coming?" They said, "Because it takes ages to get there and it costs a lot of money. We haven't got very good childcare and it is all very difficult. If it is not terribly serious, we will live with it."

She did two fantastic things. First, she frontloaded that first appointment with everything that she thought was likely to be needed so that people did not need to come back. Even better, she went out to primary care and worked with GPs and nurses to ensure that basic procedures that they could do that had previously been done in the district general were done in the GP clinic close to patients' homes.

Our transformation agenda is not simply about saying that the public have to change their ways, specifically around some of the things that Catherine Calderwood picked up in "Realistic Medicine"; it is about saying that, going forward, the NHS will use greater technology and more innovation to support people to deal with the issues as they see them.

You asked specifically about bank and agency spend, and I will start by telling the committee something that I know you already know: bank and agency spend is high. It exists because the primary objective of the NHS is to ensure patient safety. Board chief executives do not necessarily rush to spend on bank and agency staff, but they would rather do that than try to run a service that is not safe for the patient. I just want to say that. None of that means that we are content with the amount of money that is being spent on bank and agency.

I want to just share with you some things that have been done very recently, over the past year, to try to ensure that the position is improved. In the first six months of this year, the position has improved over the first six months of last year. Depending on where you select it from and whether you include all sorts of oncosts, VAT and various other bits and pieces, the data is slightly variable, but I think that we would all acknowledge that the amount is too high.

The first thing that has been done is a refresh of the NHS Scotland national framework contract. The contract was renewed this year for medical staff, with the number of suppliers rising from 10 to 35, meaning that 80 per cent of medical locums should now come through that contract. That means that there is a standard rate and, with that, a greater degree of consistency and hopefully some efficiencies.

You will have seen that, in England, consideration was given to capping the rate that is paid to agency workers. We have not gone for capped rates yet because of the patient safety issues that I talked about, but we are trying to ensure that there is a standard rate for the NHS in Scotland.

The staff bank is a little bit different. We now have over 35,000 nurses and some 2,800 doctors registered on the staff bank in Scotland.

We all recognise that agency and bank spend is higher than we would wish it to be. Using the managed agency service network, which I think the chief executives gave some evidence on last week, we are now seeing accurate reporting on the spend and we are trying to reduce that spend quite significantly. As I said earlier on, from what I have seen, it seems that the position for the first six months of this year is an improvement on the first six months of last year.

10:00

Willie Coffey: Those were very long but very welcome answers, so thank you for that.

Could I ask about a particular issue in GP practices? Last week, I had the opportunity to say to the committee and the people giving evidence that one of the surgeries in my constituency has about 13,000 patients, 2,000 of whom come there every week—on average, every single patient comes back every six or seven weeks. Given that, how successful have we been at reaching out to the public and taking them with us on this service redesign journey? The numbers put huge pressure on the surgery, and many of them—as Dr Calderwood said—probably do not need to be seen by a GP.

How do we manage the public's expectation that they are entitled to see their GP when they come to the surgery and demand that they do? There are a huge number of other qualified staff available to see them, but the evidence on the ground is that big numbers of patients are still coming in every six or so weeks to see their GP.

Paul Gray: I will ask Dr Calderwood to pick that up. One thing I just want to say is that, although we sometimes talk about inappropriate attendance—which is not a phrase that I particularly like—I do not want people to think that it is inappropriate to access the national health service. If they have a need and it is one that we can meet, we ought to be willing to meet it.

I will hand over to Dr Calderwood, but I would like to place on record the importance I attach to not doing anything that would discourage people from seeking treatment, care or advice when they need it.

Willie Coffey: It is about getting them the appropriate treatment.

Dr Calderwood: People from one of the deep-end practices in Drumchapel came to see me for a meeting. It was part of their away day for the year, which I thought was quite an interesting way to spend an afternoon; the previous year they had played tennis. They were telling me about their people who, exactly as you are describing, were coming very frequently. They examined very closely why they were attending and found that, as with many things like this, there was a pattern. As Paul Gray has said, it was not that people were attending inappropriately, but it was perhaps not the GP that they needed to see.

Therefore, they put in some dedicated healthcare assistant time, and she goes to visit people at home, as frequently as needed in fact—sometimes once a week, sometimes less than that. They did a whole series of interventions on medication and people's ability to get out and about and, in fact, they have really cut down on the number of people coming to attend. When the healthcare assistant sees them, if they need to be seen by the GP, she flags that up. She spoke very emotionally, actually, about how she has got to know people really well and can often deal with things over the phone. In part, those people just needed help of some sort.

To an extent, what we do is to say that the only person you can book an appointment to see is the GP, so we provide something without asking the person what they actually need. Innovative ideas like that one, which are not difficult—they are, in fact, much less costly than paying for more GP time—are the sorts of things that we need to be considering having on offer in GP practices.

Willie Coffey: Is that in the plan? Do you expect to see an improvement in stats of that kind over the next few years, so that we are not seeing things like 2,000 or so people who feel that they have to see their GP every week? Last week in evidence, we heard about different approaches to triaging and different surgery approaches that seemed to manage the problem reasonably well. Can we expect to see a different approach right across Scotland to try to help the problem?

Dr Calderwood: We are talking about the issue much more generally. We are building in having other types of people as part of the GP team. It will not be immediate because some of it needs to spread among general practitioners and, as you alluded to, among the people who are coming to be seen. I would say that we will see a difference in maybe a few years. We are already seeing some of what is in "Realistic Medicine" making a difference to people asking for interventions—or, rather, in people not wanting as many interventions.

The Acting Convener: I do not want us to run out of time, so if we could all be crisper that would be really helpful.

Let me just quote to our witnesses from paragraph 5 of the Auditor General's report, which says:

> "The recently published National Health and Social Care Workforce Plan - Part 1 is a broad framework to consider future workforce planning challenges and not a detailed plan to address immediate and future issues."

As I listen to you, having heard about the worldwide shortages, I look at that and think that what you have published so far does not do the business. Is that fair?

Paul Gray: First of all, if you do not have a strategic framework, your prospects of achieving anything are greatly reduced. I will ask Shirley Rogers to say a bit more.

Convener, I do not want to divert at all, but could you give me some guidance on time? When would you like to be finished, just so that we are aiming for that?

The Acting Convener: Do not worry, it is my job to worry about that. You worry about the NHS; I will worry about this committee.

Paul Gray: All right, thank you. It was just to try to moderate our responses appropriately.

The Acting Convener: I will do that for you.

Paul Gray: Thank you. I think that we do need a framework but, as I was seeking to make clear earlier, that does not mean that we have stopped doing all the other planning that we are doing—we have not suspended everything else and now we are doing this. There is already planning in place that is producing health professionals—let me not give you a list of those. Shirley, do you want to say more about the detail?

Shirley Rogers: Absolutely. The planning process to give us a sustainable supply of people to work in the NHS never stops—you do it, you review it, you see what you get, and you do some things less and some things more.

General practice is a good example of an area where there is an acknowledged shortage. The work around trying to find a more sustainable supply of general practitioners involves, for example, the opening this coming year of the first postgraduate medical course in Scotland. We have never had a postgraduate medical degree course in Scotland before. We are doing that partly because we want to give people the opportunity to practise medicine and partly because we believe that doing medicine on a postgraduate basis is more likely to give us people who will want to practise medicine in Scotland. People will be more mature in making life choices at that point. We have also seen evidence that appropriately designed postgraduate medical courses, which this one will be, help to direct and encourage people towards general practice—there is good evidence of that from Keele University, for example, which is a university medical school in England that produces one of the higher proportions of general practitioners, and it does so by giving people exposure.

Will that approach give us everything that we need? No. Will it start to give us the people we need to see coming through the supply pipeline? Yes, it will.

You make a very valid point about a framework, but remember as well that every year I get from the boards 22 workforce plans—

The Acting Convener: They clearly have not worked, which is why having a single plan is something that you accept is important. The first part was about the NHS workforce, so I would have expected to see detail there; but, according to Audit Scotland, the detail is not there. Naturally, we have concerns about the efficacy of this moving forward.

Anyway, I have taken up enough time.

Bill Bowman (North East Scotland) (Con): We have perhaps touched on this a little bit. What is the chain of command in NHS Scotland?

Paul Gray: I am accountable to the Parliament and the cabinet secretary of the day is the responsible minister. I am also accountable to the permanent secretary, who is my line manager. As I have explained, the chief executives are delegated authority by me. The chairs of the NHS boards are appointed by the cabinet secretary, as are the members. I appraise the chairs of the larger boards. Directors who report to me appraise the other chairs. Each chair is appraised on their performance consistent with the standards set by the Commissioner for Ethical Standards in Public Life in Scotland. The responsibility for the total budget rests with me as an official and with the cabinet secretary as the minister.

Bill Bowman: How does that work in day-to-day executive terms?

Paul Gray: In day-to-day executive terms, when I have delegated to the NHS chief executives and hence put that delegation within the scope of their board, the expectation is that the executive decisions at board level will be made at board level; otherwise, there is no system of delegation. I also have directors who report to me. Shirley Rogers and Catherine Calderwood are two of those. I am their line manager, and I am the line manager for the members of the health and social care management board.

Bill Bowman: We had chief executives here last week who said, as has been repeated, that there is no plan. However, you say something else. Something does not seem to work in the way that you delegate.

Paul Gray: I am trying to find a way to answer that question that will be useful to the committee. It is reasonable that the people who are closest to the preparation of the plan will know most about it.

I have said—and it remains my view—that it is not accurate to say that there is no plan. I think that Mr Davison was one of those who said something along those lines, but he went on to say that he meant that there is no single plan for everything. That is true, but that is not what we are here to discuss, as I understand it. We are here to discuss the fact that there is a workforce plan, the first part of which has been published and the second and third parts of which are in development.

I am not sure how one could conclude from what was said that the delegation has not worked.

Bill Bowman: How does the delegation work? I read the documentation that you provided, which seems to be passive: you give guidance and suggest how you do things. In other organisations, the chief executive makes sure that what he wants to happen happens.

Paul Gray: Each board has a local delivery plan for which they are held to account. I have a whole team that does that. As I have explained to Mr Kerr, if a point is reached at which I feel that I need to make a decision and give a direction, I can do that. If I need to intervene, I can do that.

Sorry—I will stop there. I want to understand your question.

Bill Bowman: I get the feeling that the delegation happens and that is the end of the matter.

Paul Gray: No, definitely not. I meet the chief executives in plenary session once a month, and I meet them individually more regularly than that. I do not meet every chief executive individually every month; I do not want to convey that impression. However, the health and social care management board receives reports monthly on financial performance, workforce and delivery—in other words, access targets. We do not hand over a delegation and then sit and wait to see what happens. It is subject to regular monitoring, which is reported on. There is a health and social care audit group that meets quarterly.

I am happy to go into more detail now, if you wish, or to provide the detail of that in writing.

The Acting Convener: We would be happy to have that detail in writing.

I am hearing a lot from you about different planning groups and all the rest of it, but the Auditor General was absolutely clear that current lines of responsibility and decision making are unclear and that regional workforce planning is not working as was originally expected. There have been misunderstandings around workforce planning. Let me quote Tim Davison. When asked who is responsible, he said:

"All of us—from health board to Government—have failed to pull together the link between short-term operational delivery and longer-term workforce planning."—[*Official Report, Public Audit and Post-legislative Scrutiny Committee*, 2 November 2017; c 13.]

Is that not the case?

10:15

Paul Gray: No, I do not agree. As I said earlier, convener, I do not disagree that there are things that we could have done better, but that is why we are doing what we are doing. I am happy that each chief executive accepts responsibility in line with what Mr Bowman has been asking about, but I do not agree that there has been some collective failure to plan for anything. As I pointed out, we have 156,000 staff in the health service. We have them organised to deliver and we did not get that from nowhere.

The Acting Convener: Is the Auditor General wrong in her comments in the report?

Paul Gray: The Auditor General is commenting, properly, on the sufficiency of what we have. We are still working on that. Nobody is denying that, but I do not agree that there has been some kind of general failure to plan for a workforce. We have a workforce—it is here; it exists.

The Acting Convener: But there are not enough of them, they are not in the right place and they do not have the right skills mix.

Paul Gray: There are enough of them in some places; there are not enough in others. I have been open about that.

The Acting Convener: Sorry, Bill. Do you have any further questions?

Bill Bowman: Setting that issue aside, I have one other question that follows up on something that you said. I think you said that you have been listening to general practitioners recently. By chance, I was at an event last week at which a senior GP pointed to a number of good things but commented that there is a lack of joined-up thinking in the NHS. Does that strike a chord? Perhaps Dr Calderwood can comment if she is closer to the issue.

Dr Calderwood: I think that we would now say that primary and secondary care are joining up. Many decades ago, individuals in primary and secondary care knew each other. However, as the numbers have expanded—I take it that you are talking about doctors—ironically, those good relationships have probably been less good.

We have some good initiatives, which I will address briefly. In NHS Highland, the number of people coming through the urology department was very difficult to cope with, so the board took the approach of having a senior person look at the situation. That is not traditional. Usually, the senior person looks in only at the end or at the most difficult stage.

The senior urologist was able to say that lots of people did not need to see a urologist, although he recognised that they needed some help. The GPs were not sending them just for the sake of it. NHS Highland has therefore gone out to the GPs with teaching and discussion to say, "If this is what the person has wrong with them, why don't you try this first? That is what I would tell you if the person waited for 12 weeks and came up to the clinic at the hospital."

That relationship needs to be built again. In the past, the GP would have lifted the phone, but now that is not the way. There is no such access. The new collaborative is looking at different ways of working with out-patients and reintroducing that sort of service whereby there are people in secondary care with expertise whom the GP is able to phone for advice. That will re-join some of those disjointed services that you are talking about.

Bill Bowman: It is hard to beat the personal touch.

Dr Calderwood: And the telephone.

Alex Neil (Airdrie and Shotts) (SNP): Can I begin with a factual question? What is the current status of Harry Burns's report on waiting times? That obviously impacts on what we are talking about.

Paul Gray: We expect to have that published shortly.

Dr Calderwood: Yes, soon.

Alex Neil: Before Christmas?

Dr Calderwood: Yes.

Paul Gray: Yes.

Alex Neil: That will be interesting, because that report will potentially have an impact on the workforce.

I will begin by focusing on primary care—particularly GP practices—with a short factual question. What is the current status of the negotiations on the new GP contract in Scotland, and when do you expect the new contract to be in place?

Paul Gray: I expect the contract to be published for consultation next week. When it will be in place will depend on the consultation.

Alex Neil: The shortage of GPs is an immediate issue that requires imaginative approaches. I appreciate the initiatives that have already been taken, but we all know of the problems in GP surgeries. My own GP surgery is one GP down at the moment, and it will be next summer before it gets a replacement. Wherever anybody lives, they hear stories about the pressures that their GP surgeries are under.

I have three questions relating to that. I will start with the first one—that is always a good place to start. Last week, we saw figures for net GP income and the share of the contract income that goes to the GP personally north of the border compared with what happens south of the border. The latest available annual figures show that the GP's net income in his or her pocket, less tax, was about £109,000 south of the border but £89,000 in Scotland. How big a factor is that differential in retaining and recruiting GPs?

Paul Gray: There was, of course, a difference in the number of patients as well.

Alex Neil: Yes.

Paul Gray: There was a ratio. I genuinely do not want to pre-empt the publication of the contract for negotiation, Mr Neil, because we want to be respectful of the British Medical Association's position. We have sought to address some of those concerns in the negotiations but, for the precise detail, we await the publication of the contract.

Alex Neil: Is there evidence that that is one of the reasons why we face a challenge in retention and recruitment?

Paul Gray: There is some evidence of that. However, what I am hearing is more concerns about straightforward pressure of workload, being able to take time off and being able to give patients who have complex needs the time that they require. Dr Calderwood may wish to add to that.

Dr Calderwood: This is anecdotal, but I have never had a GP say to me, "If only I could be paid more".

Alex Neil: I have.

Colin Beattie: I have, too.

Dr Calderwood: They talk to me about different, clinical things, because they are talking about their patients.

Alex Neil: Yes. Okay. I will move on to my second question about GPs.

Last week, we heard from Tim Davison an example of a change in work practices, and there are other examples of that. There was one in Fife a number of years ago that we called, for shorthand, the introduction of the Alaska model. It worked in a GP practice in Fife but, unfortunately, when the doctor in the practice who was doing it left or retired, the other doctors would not carry on with it, even though the patients—and everyone—thought that the evaluation was very positive.

Tim Davison gave us a similar example of a GP surgery in a deprived area of Edinburgh that had been under enormous pressure—he did not name the surgery in his evidence last week—where people were waiting two or three weeks for an appointment because the surgery was under so much pressure. It introduced triaging by a doctor so that, if somebody had a foot problem, they were referred to a podiatrist and so on, along the lines that the chief medical officer has outlined. That has been a tremendous success according to both

doctors and patients, and the pressure is much reduced.

Tim Davison said that, on the day when he visited, there were appointment slots that were not filled and were available for people who needed to see a doctor on that particular day. However, he also said that the other doctors' practices in Edinburgh were not prepared to introduce a similar system.

As a matter of urgency, should we not be trying to get GPs to change their work practices? That is part of the solution to the challenge. We know that the BMA has always supported restrictive practices in the past, but it is doing most of the bleating. Maybe this will be part of the contract that will be published next week but, when there is clear evidence of the effectiveness of changes in practice such as those in Fife, using the Alaska model, and in the surgery in Edinburgh, there is surely a responsibility on GP practices to pretty quickly be more flexible and be prepared to change their work practices. Indeed, it is in their interests to do so, assuming that the new contract will not penalise GPs for any reduction in the number of patients that they personally see.

The Acting Convener: That was a long question for you, Mr Gray.

Paul Gray: I ask the chief medical officer to answer.

Dr Calderwood: Shirley, do you want to comment?

Shirley Rogers: I referred earlier to the important relationship between performance and workforce planning. Going back to Mr Bowman's question, I can assure you that, if we see those relationships not performing in the right way, we will be interventionist in that space. I think that Alex Neil was asking, "What do you do when it isn't working?" I will give an example. If a board does not put forward a suggestion about how it wants to recruit as part of our international campaign, I will speak to it directly. In respect of NHS Lothian, there have been a number of instances when I have intervened to say that it needs to do something and we have funded particular activities or required it to do certain things.

Returning to Mr Neil's point, I will try to pick up both of the points that were made in what was a very big question. Let me try to unpick the various bits of it.

Alex Neil: The background was big, but the question was fairly short.

Shirley Rogers: Indeed. There is a broad differential in salaries for GPs in Scotland. The breadth of the difference between the figures that we use to establish the average is quite considerable. There are some general practitioners who are very high earning and some who are not. There are still people who are operating as independent contractors in their GP model, but there are also a number of salaried GPs, and different models are emerging. That reflects how people want to practise and their different relationships with their employer in the wider sense of the word and the people whom they provide services to.

Where we find evidence that we have a system that provides a better service for patients, our job is to present that evidence as objectively as we can and seek to remove any barriers that prevent that from being adopted. That is increasingly relevant to some of the regional activity that is taking place. I take Mr Neil's point about regional workforce planning. Of course, we did not really have a regional configuration to the NHS in Scotland until this year, so it is in its embryonic stages. However, we are actively working with the boards and supporting them on transformational change.

This year, we have allocated funding to all the regions—it is relatively modest at this stage—to support that transformational endeavour. They have local leadership on the ground. To some extent, it is all about going and presenting that evidence and saying, "Patients get a better outcome through this model. Let us work with you to remove whatever barriers there might be to the implementation of this model".

Alex Neil: So, given the example that we heard from Tim Davison, NHS Lothian should be going to all the other practices and saying, "We have evidence that this system works much more effectively and is better for both patients and doctors, ergo we expect you to implement something similar."

Shirley Rogers: We have examples of that happening in Aberdeen and various other places. The short answer is yes.

Alex Neil: Is that not the problem—that we have examples of excellent practice throughout the health service? I remember the NHS Western Isles digital pen technology. That was introduced very quickly once it had been developed and it produced fantastic effects, but after five years it has still not been spread across the national health service in Scotland.

There is a real problem in getting good practice spread across the system, particularly where it is new. There are a lot of good examples of very innovative behaviour, but it tends to be in pockets and it tends to be difficult to get it spread and to get the pace of change. It is not that it is not happening anywhere in the health service in

Scotland. It is that the pace, scale and spread of the change is too often confined to small pockets.

10:30

In the case that I mentioned, given the challenges that the health service in Lothian is facing, the priority should surely be for NHS Lothian to work with all the other practices to try to get them to do something that is blatantly very successful. I am not asking you to give anything away, but will the new contract give you the teeth that are required to make such changes? Obviously, the situation is dynamic and there will be other changes during the period of the contract, but we do not know what they will be yet. Surely we need to be able to ensure that such improvements can take place, because we are all about improvement. A lot of things are working very well, but we need to improve all the time in the health service. The contract must facilitate improvement and not be a barrier to it, which is what the current contract probably is.

The Acting Convener: I think that Mr Neil is trying to answer the question himself, but do have a go.

Paul Gray: I hope that the contract, if it is accepted, will remove certain of the barriers. Some of them might just be down to basic workload. In other words, if people do not have time to do anything other than see patients, they do not have time to change anything. I would not want to go further than that, convener, as I do not want to intrude into what the contract might or might not say.

The only other point that I would make is that ultimately, as I have said in a couple of responses, we can impose things. However, if we do that, the likelihood of getting a good outcome is much lower than it is if we get it by agreement. That is what the chief medical officer and others are doing through realistic medicine. They are promoting the principles of realistic medicine so that, when the practice comes to fruition, it will be different.

Alex Neil: I agree with that.

I will move on to the third issue, which also relates to the availability of GPs. There is clearly an element of GPs, particularly younger ones, going abroad, and particularly to Australia. I talked to somebody yesterday who had been talking to a recruitment agency that had interviewed 200 GPs in Scotland and 80 of them intend to emigrate to Australia. That is a major leakage of skills from GPs in Scotland.

Obviously, work/life balance and a range of other things come into this, but I believe we should be doing something to try to keep those GPs in Scotland. We will not be able to keep them all. Maybe we should be going to Australia and trying to get some of those who have already gone to come back. However, it strikes me that that is a specific issue that we need to understand so that we know whether there is anything we can do anything about it. There might not be.

I do not know whether Shirley Rogers wants to comment on that.

Dr Calderwood: We are thinking of moving more sunshine to Scotland as a first intervention.

Alex Neil: Come to Ayrshire, Catherine. [*Laughter*.]

Shirley Rogers: If I may, I will make an observation before I get into the meat of my response. A couple of weeks ago, I was in conversation with a young junior doctor who showed me a photograph of an unnamed Scottish hospital in the rain and the rather attractive sunshine at the Melbourne A and E department. His response to me was, “While I’m young, I want to go and do some surfing as well. Can you fix the weather?”

We need to recognise that we operate in an international marketplace and that our responsibility is to make the roles that we have on offer in NHS Scotland as attractive as we can. Alex Neil touched on the importance of salary in that space. For the vast majority of the clinicians I talk to, that is part of it, but not all of it. They want to have good shift patterns—the DG talked about the work that we have been doing around improving the working lives of junior doctors and various others—and they want to have high-quality work. Sitting in the public gallery is a Scottish clinical leadership fellow, and giving people the opportunity to develop their leadership skills is something that has been phenomenally successful for us. We need to improve the attractiveness of the working lives of everybody in the NHS in Scotland, but not least our doctors, simply because of their geographic mobility.

Many take the opportunity to go and travel and then come back to practise in Scotland for the rest of their careers. You are absolutely right to say that we need to do something while they are away. You will have seen, for example, that NHS Grampian is currently recruiting in Australia. It is working with people whose time there—a couple of years or whatever—has come to an end and who are thinking about coming home. We are actively recruiting overseas to encourage people to do that, and not just by saying, “Come back and do what you were doing here before.” We have an international training arrangement that is successful in attracting people from all over the world who can come and train here and spend their time here. We have evidence that suggests—UK Visas and Immigration rules permitting—that if

they are able to continue in practice where they have trained, a large number of people seek to do that. You are absolutely right.

Alex Neil: My final question is on the workforce plan. The shape and size of any workforce depends on the service. Workforce planning is not a perfect science and we will never get it 100 per cent right. That is just a fact of life because of all the changes that have been mentioned. However, we will get it more right if we have a good understanding of the level and shape of demand for services in the future.

A report that was published during the summer—I think it was published or commissioned by you—showed that 25 conditions make up 70 per cent of NHS activity in Scotland. If we get that 70 per cent right, there is a good chance that we will hit the mark better. There are methodologies that can be employed to improve the accuracy of forecasts. Have you brought together to inform the workforce plan—in one document or a number of documents—a researched and evidenced forecast of the level and shape of demand for NHS services in Scotland over the next few years?

Shirley Rogers: As I mentioned, we are working with, I think, 79 stakeholders and organisations that provide us with some of that evidence. We have worked closely with COSLA, SOLACE and agencies such as Scottish Care to look at the impact that we expect from the ageing population. We are looking particularly at how we will support that through additional skills around care for older people in various places. It is not complete—as you said, it is an art and not a science—but the short answer is yes. We are doing more and we need to do more of that.

Alex Neil: If you have a forecast of the level and shape of demand, is it possible for the committee to get a copy of it?

Shirley Rogers: I do not have a place. That is what I am saying. We are working with a number of stakeholders, but I can certainly share with you some stuff that I have about some of the indications that we are working on at the moment.

Alex Neil: Thank you.

The Acting Convener: That would be helpful.

Monica Lennon (Central Scotland) (Lab): Good morning. The

"financial outlook for the next three or four years is really bleak".

Those are not my words but the words of Tim Davison from NHS Lothian, who was one of our witnesses last week. He said that if we took one message from him it should be that

"short-termism in workforce planning has not helped".

I think that we have realised that today. He also said something that other people have not said:

"We need to raise our gaze and to plan beyond austerity. Whether the solutions are at UK level, at Scottish Parliament level or whatever, a growing population with growing health needs will cost more money, and that needs to be addressed fundamentally."—[*Official Report, Public Audit and Post-legislative Scrutiny Committee,* 2 November 2017; c 47.]

Mr Gray, you are the chief adviser to the Scottish Government on the NHS. What conversations are you having with the Scottish Government about that? Do you recognise the premise of Tim Davison's comments?

Paul Gray: I assume that you are not asking me to tell you what advice I give to ministers, because I would not do that in this setting, but let me address your point briefly.

I recognise that the financial pressure on public services, and not just on the health service, is high. There is no doubt about that. That is the case in Scotland, in the rest of the UK and internationally. Pressure is growing because of the ageing population, as we have all agreed, but let me tell you some of the components of what we are doing about that. Realistic medicine is one response and the proposals to establish a new public health body are another component of what we are doing about it. The workforce planning that we are doing is another component, and then there is the transformation planning.

Will you give me a sense of what you are reaching for? As I said, I am not about to discuss here the advice that I give to ministers.

Monica Lennon: I would not expect you to do that. Let me go back to Tim Davison's comment about the financial outlook for the next few years being bleak. The witnesses told us that we should not expect a big increase in numbers in the workforce. There is a whole range of things that need to happen—redesigning services, training, people working differently, multidisciplinary working and so on. Recognising that the financial outlook is difficult and it is very difficult to do affordable workforce planning, Tim Davison, the chief executive of NHS Lothian, told the committee:

"We need to raise our gaze and to plan beyond austerity."—[*Official Report, Public Audit and Post-legislative Scrutiny Committee,* 2 November 2017; c 47.]

He said that we all have to get a grip on that, whether we are talking about UK or Scottish Parliament level. Do you think that his comments are helpful? Do people need to do that? You are the most senior person that we can speak to about this today; how would you develop that thinking?

Tim Davison is a senior person in the NHS in Scotland; is he talking sense?

Paul Gray: I probably have a more positive outlook on life generally—you might well say that that is not evidenced to the committee. As accountable officer, I work within the financial settlement that I get and I plan within the financial settlement that I get. I respect the fact that Parliament decides on a budget and I work within that. That is my job as a public servant.

I am convinced that we can continue to deliver excellent services within the NHS in Scotland and across the breadth of health and social care. I am equally convinced that transformation is essential to allow us to do that. We cannot simply carry on and produce a plan that says, "More, better, faster". That will not work. We need to transform, which is why Shirley Rogers, Catherine Calderwood and others are leading work on different aspects.

I accept that there is financial pressure—I am not sitting here pretending that there is not—but I think that if we take the view that with £13 billion we ought to be able to do something very good indeed for Scotland and its people, that positive outlook allows us to plan, as Tim Davison suggested, beyond austerity. If we are constantly thinking about the difficulties we will become absorbed with them. That does not mean that we can ignore them; we cannot. The pressures that we have spoken about are real and they press on staff and on patients.

I will ask Catherine Calderwood and Shirley Rogers to say a little—I am conscious of the convener's strictures on time—about what we are doing to plan ahead beyond this year and next year.

Dr Calderwood: I think that some of the discussions that we are having here are becoming much more common in the clinical workforce. There is a recognition of austerity as something that we must deal with as we get through the day job, and we are looking at changing the way in which people work—we have given many examples in that regard. We also know that we need to talk about what the people of Scotland need from their healthcare services.

Many of the ambitions of the new public health body will be to do with prevention, because we know that we can prevent much of the ill health that we end up treating. There is also much more evidence on how we can influence the health outcomes of children and young people—right back to babies before they are born. We have more evidence on what we can do now to salvage better health for the future, and we have introduced that thinking into how we train our staff and talk about public health and preventative spend, to some extent, because some of this will need investment now to prevent problems in the future.

10:45

Shirley Rogers: Let me turn that into a workforce planning question. It takes someone 15 to 20 years from joining medical school to become a consultant. I do not have the luxury—nor would I seek it—of being able to predict the financial outcome for this year, next year or 10 years' time, so I try hard to workforce plan on what I believe the population need will be.

I contend that we are already training numbers in anticipation of life beyond austerity. If we were not doing so we would be stopping now and saying that we cannot afford our approach, when in fact we are investing more and have more places in medical school and nurse education than we had previously.

To come back to Mr Neil's point about arts and sciences, it is very difficult to say, "In 10 years' time we will have a boom as a result of X; therefore we will need lots and lots." What we need to do is to try to anticipate the needs of our population and take a view on what we believe will be some of the technological, innovative or team-working solutions that might be able to provide healthcare in those circumstances, so that we can give our best shot at getting ourselves a ready supply pipeline.

My activity at the moment is all about increasing that supply pipeline. Although having that supply pipeline in every place where we want it might cost more, in terms of our establishment, it will save us money—we have already discussed the use of bank agency staff and various other things. Mr Davison's contention about planning and taking the longer view, whether that is about riding the peak of austerity or anything else, reflects exactly where we need to be and why workforce planning in the NHS is more complicated than it is in some other parts of the world and some parts of industry, simply because our supply pipeline is so long.

Monica Lennon: When I asked Tim Davison to say how challenging it is, on a scale of one to 10, with 10 being the most challenging, to achieve affordable workforce plans, he said, "Ten". In the joint submission that we received last week, our witnesses identified the problem of

"Limited information on future funding coupled with the SG requirement to provide workforce projections for three years".

Should workforce planning be so difficult? A score of 10 on a scale of one to 10 is not great.

Shirley Rogers: I do not know how Tim Davison calibrates that but I take the point that it is a difficult challenge. In any long-term planning, we have to take into account a number of scenarios, and we try to do that. However, as I said earlier, there are certain things that are best done nationally, by taking a view that is not just that of representative chief executives. If I was reflecting the daily or annual budgetary cycle in the way that chief executives are sometimes required to do, I might not make the long-term investments that we are currently making. There is a reason why we do medical school intake at a national level and take a view about the long-term sustainable future of the NHS.

Monica Lennon: Mr Gray, I know that you are a positive person, and I hate to be gloomy, but I cannot help but think about some of the heartbreaking stories that we hear. I think that all of us in this room fully admire and appreciate the work that NHS Scotland staff do for all of us every day, but members of the Scottish Parliament have busy surgeries and full in-boxes, and we hear about the times when things are not working well. To be frank, sometimes that is because of workforce planning issues; there are not enough people, or people are tired and stressed and appointments get cancelled. We have constituents who are waiting more than 12 months for operations. I asked the witnesses last week whether that is inevitable. Do we have to say to our constituents that it is inevitable? None of us really enjoys having to bring such cases to First Minister's question time or portfolio question time.

You and I were both at the Scottish health awards 2017 last week, where we were celebrating best practice and exceptional practice in NHS Scotland. Your message to the Opposition politicians in the room was that the next time we have an Opposition debate on health we should sing from the rooftops that we in Scotland have the best NHS. None of us is here to criticise the NHS in Scotland, but when we think about patient outcomes, how can we reassure our constituents and their families that there is a coherent plan, which will be properly resourced, and that we are not just going to accept that in a small percentage of cases things will not go well? You are an optimist, Mr Gray. What would you say to those people?

Paul Gray: I would say that we take workforce planning very seriously, that we will take seriously the views and recommendations of the PAPLS committee, and that I know and accept that there are cases in which we do not treat people as quickly or as well as we should do—and we should not accept that that is inevitable.

If we are successful—and I intend that we should be—in what we are doing through the realistic medicine approach, to ensure that people are not overtreated or put on lists for treatment that is not likely to benefit them, we will free up space to treat more quickly people who actually need to be treated. If we are successful—as, again, I intend that we should be—in transforming in the ways in which we need to transform, and if we are successful in having a conversation with the public, through the work that we are doing on a new public health body and population health, about what individuals themselves can do to contribute to their own wellbeing, we will see changes.

The current situation is difficult. I am not denying that. I trust that it is clear that I am not enjoining Opposition politicians suddenly to say that everything is fine and we should simply ignore issues that exist. Politicians from all parties—the party of Government and the Opposition parties—bring issues of concern to me, to Shirley Rogers and to Catherine Calderwood. That is legitimate. Politicians should continue to do that, and under no circumstances would I try to persuade them not to do it. I am grateful to members for the way in which the contribution of NHS staff is recognised but I am not here to say to you that everything is fine. We have to accept that there are certain areas in which our performance is not what it should be.

Monica Lennon: I am conscious that members of the public might be watching—you never know—and I am glad that you clarified a point that a committee member made about inappropriate visits to general practitioners. None of us wants to put people off going through the door of their GP practice or elsewhere.

At last week's meeting, I talked about the people who do not make those visits, who are harder to reach. I hope that you do not disagree with the Auditor General for Scotland, who pointed out that Scotland's health is not improving and significant inequalities remain. Dr Calderwood mentioned the deep-end practices, and there is innovative practice in that regard, which we need to consider.

We should make clear that the message from NHS Scotland is not, "Don't come to your GP". In Lanarkshire there was an innovative project in which nurses and health visitors proactively visited people who were not attending the doctor's surgery, to make sure that they were okay. I think that the project stopped—I am not sure why. Where we have good practice such as you described, how can we roll it out? There are savings that could be made, but such practice will also help people to get better and will help to close the gap, in the context of health inequalities.

Paul Gray: Just as I have sought to prevent as far as possible the use of the phrase "inappropriate attendance", I am also on

something of a campaign to stop us thinking about people as being hard to reach, because that almost makes it the fault of the person who we are not reaching. As far as I am concerned, the responsibility is with us to reach them, not for them to find some way of getting to us, if we are making that difficult. One of the things that we are doing is engaging with local communities to understand what would motivate people to come into contact with a health professional. That does not need to be a GP. Sometimes it does not even need to be a health professional; it might be someone who can provide advocacy services and support. Dr Calderwood can say more about that.

Dr Calderwood: One of the successes of the deep-end practices is that they are embedded in communities and understand them. I do not know whether you are familiar with the links worker programme, which has made a big difference in a short time. The programme employs people to make the links between benefits and all sorts of different services—it might be the GP or other services, when people have problems that the health service cannot solve.

We are understanding more about health literacy in Scotland. The statistics are not easy to listen to: some 23 per cent of working-age adults would not be able to calculate the dose of paracetamol for a child from the instructions on the bottle, and 38 per cent of working-age adults do not fully understand the bowel screening leaflet that advises them to come forward on their 50th birthday. Some 4 per cent—one in 25 people—have no health literacy at all. That means, for example, that they do not understand what their kidneys are, what they do and why a problem would be important.

NHS Tayside has embraced some of those figures and is working with community groups. It is not necessarily about literacy and numeracy; it is much more about understanding why it is important to come forward. I think that some of our health inequalities are to do with our messaging. I have spoken publicly about that; we claim that people are hard to reach, when in fact our messages are not being understood or even reaching people.

Our medical schools have really taken that on board. Again, this is work in progress, but until this point I do not think that people really understood the issue. We work away at trying to get people to come to us when they do not realise that there is something wrong, and I talk about the worried well, but, more important, there are the unworried unwell. There are schemes, workshops, and pieces of work in that regard—some of it comes through education and much of it goes beyond health. We need to start by better understanding our deprived communities in Scotland.

The Acting Convener: I have a final question, before I let you all escape. The national workforce plan that was published in 2017 does not include details on expected workforce costs that are associated with NHS reform. What progress have you made in establishing those costs? Can you share that with us today?

Shirley Rogers: Can you be a bit more specific?

The Acting Convener: Okay. We have spent a bit of time talking about stories about changes that people have made or additional training, so that you have a multiskilled workforce. All that costs money. I want to know whether you have thought about how much it costs and whether you built that into the plan, because the plan did not mention those changes.

Shirley Rogers: As you will be aware, the commitment to a national workforce plan is part of our transformational change delivery programme. We had the opportunity to create some regional leads for that—the chief executives whom you saw last week, largely. The regional leads have been working to produce plans that will include that transformational component. We have seen initial drafts of those plans, and there is a commitment that plans will be available for publication by the end of this financial year; we can do the consultation thereafter. The transformational plans will have a service change element, where appropriate, and regional workforce plans will be associated with them and will start to help us to identify costs and so on. Where we are looking specifically at clinical therapies—in the context of some of the stuff that Catherine Calderwood has been leading on, to do with realistic medicine and various changes to practice—we are starting to get responses from the CMO and chief nursing officer about some of the training costs that might be associated.

The Acting Convener: When will we have the global figure?

Shirley Rogers: The commitment that we have made is to revisit the national workforce plan next spring; next spring that should be part of that plan.

The Acting Convener: Will you be making a budget bid in this budget, through health, for additional money for the changes that are needed, or will we see the figure in spring and wait another year before anything happens?

Shirley Rogers: No. I mentioned earlier that we were allocated some transformation funding for this year. Most of that has been deployed in building the capacity to do some of that work at regional level. I expect us to have some budget allocation for that next year, too. You will understand that at the moment budgets are not yet set, so we are in the process of discussing that.

11:00

The Acting Convener: Okay, but what you have described is money to buy capacity to formulate what the costs will be. What is the money that is going to make a difference on the ground?

Shirley Rogers: If I described it as simply buying capacity, that is not precisely what I wanted to talk about. Some of the money has built capacity and some of it is funding initiatives. We were asked earlier about digital; some of the money has gone into that. You will get a budgeted assessment of transformation costs as part of the work that we expect to be able to publish next spring.

The Acting Convener: If you cannot provide me with the costs, it would be helpful to learn about the process, so that the committee can be clear about when we will see a figure and how that is built into the budget.

On the basis that there are no other questions from committee members, thank you very much for your attendance this morning. I now move the committee into private session.

11:01

Meeting continued in private until 11:20.

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