# HEALTH COMMITTEE

Tuesday 5 October 2004

Session 2

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by Astron.

# CONTENTS

## Tuesday 5 October 2004



## HEALTH COMMITTEE

**22nd Meeting 2004, Session 2**

**CONVENER**

*Roseanna Cunningham (Perth) (SNP)

**DEPUTY CONVENER**

*Janis Hughes (Glasgow Rutherglen) (Lab)

**COMMITTEE MEMBERS**

*Mr David Davidson (North East Scotland) (Con)
*Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
*Shona Robison (Dundee East) (SNP)
*Mike Rumbles (West Aberdeenshire and Kincardine) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

**COMMITTEE SUBSTITUTES**

Robert Brown (Glasgow) (LD)
Paul Martin (Glasgow Springburn) (Lab)
Mr Stewart Maxwell (West of Scotland) (SNP)
Mrs Nanette Milne (North East Scotland) (Con)
Ms Sandra White (Glasgow) (SNP)

*attended

**THE FOLLOWING ALSO ATTENDED:**

Carolyn Leckie (Central Scotland) (SSP)

**THE FOLLOWING GAVE EVIDENCE:**

Riona Bell (Scottish Funding Councils for Further and Higher Education)
Bridget Hunter (Unison)
Tom Kelly (Association of Scottish Colleges)
James Kennedy (Royal College of Nursing Scotland)
Mr Andy Kerr (The Minister for Health and Community Care)
Christina McKenzie (Nursing and Midwifery Council)
Professor Jim McKillop (University of Glasgow)
Professor Jack Rae (University of Paisley)
Lydia Wilkie (Food Standards Agency Scotland)

**CLERK TO THE COMMITTEE**

Jennifer Smart

**SENIOR ASSISTANT CLERK**

Tracey White

**ASSISTANT CLERK**

Roz Wheeler

**LOCATION**

Committee Room 6

# Scottish Parliament

## Health Committee

*Tuesday 5 October 2004*

[THE CONVENER *opened the meeting at 14:04*]

## Subordinate Legislation

### Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 10) (Scotland) Order 2004 (SSI 2004/412)

**The Convener (Roseanna Cunningham):** I welcome the new Minister for Health and Community Care to the committee. I take it that attendance here is his first official duty in that role. I have no doubt that he is extremely well briefed and has become an expert in amnesic shellfish poisoning overnight. Here, too, is Lydia Wilkie, who is assistant director of the Food Standards Agency Scotland. The Subordinate Legislation Committee considered the order that is under consideration this morning, and has no comment to make on the instrument. I ask whether any member wishes to seek clarification from the minister and his official on the instrument.

**Mr David Davidson (North East Scotland) (Con):** Good afternoon, minister. Welcome to the hot seat. I wish to ask you two or three things so that you can convey to the committee some details of your thinking on this matter. Do you agree that, by moving the balance of control activity from monitoring to processes, it would be possible to improve public safety and to protect the industry while reducing the amount of Government expenditure that is necessary to manage the problem?

**The Minister for Health and Community Care (Mr Andy Kerr):** Just that one question, is it?

**Mr Davidson:** That is the starter.

**Mr Kerr:** First, it is a great pleasure to be here. I look forward to passing many long hours with the committee in discussion of issues that are critical to the health of Scotland.

In response to the question, we should consider the model that the Irish have adopted. They have still to fulfil the requirements of European legislation and I doubt that the balance or shift in resource that David Davidson outlined would exist to the desired degree. Above all, we seek to listen to those who have direct experience of such matters and who are entrusted with protecting our public health. I think that any shift in such a system would be to the detriment of consumers and, more important, the industry.

**Mr Davidson:** The minister will be aware that scallops from Ireland may be sold here at times of the year when they have the same problem that we in Scotland have—when Scottish scallops cannot be sold in Scotland. The Irish use end-product testing. Does the minister intend to have any work carried out to consider other ways to deal with the problem? I gather that the current regulations are being met only temporarily.

**Mr Kerr:** I disagree that the current measures are being met only temporarily. We are not using the tiered system that has been promoted in some parts of Europe, but that does not mean that we are only partly meeting the requirements. We are always looking out for better ways of doing things; as I said, we have looked at the Irish model. What we see as being our major focus, however, is that we should underpin the values that are enshrined in the European directive to ensure that we deliver what we seek on public health—as the Government, through agencies, is responsible for doing. I do not think that what Mr Davidson suggests is an appropriate way forward. Perhaps Lydia Wilkie would care to comment more fully on those matters.

**Lydia Wilkie (Food Standards Agency Scotland):** I presume that David Davidson was talking about the Republic of Ireland, rather than Northern Ireland; naturally, we organise things on a United Kingdom basis. The Irish system also uses monitoring, but theirs is a very different shellfish industry to ours. Ours is an awful lot more complex, particularly in relation to the offshore scallop industry. The Irish do carry out monitoring, however, and are under the same requirement of due diligence that applies to our industry, which is to ensure that the product is safe through end-product testing. We have looked into that over the years, and we do not consider that there is any difference. Their industry is completely different, but that reflects the scale of the industry.

The major work that we are undertaking at the moment is intended to reflect the likely changes that will arise from consolidation of the hygiene regulations—the new European rules that are coming in. We are discussing in great detail with industry and enforcement representatives what a new regime might look like. There could be significant changes from the offshore testing regime that currently applies. We are dealing with that very much in consultation with industry and with enforcers. Public health will always remain our priority.

**Mr Davidson:** Do you have a timescale for when the details of that might be published?

**Lydia Wilkie:** The European consolidation regulations are already published, but they contain flexibility for each member state to produce regimes that will, in a proportionate way, meet the food safety requirements. Those are due to come into effect on 1 January 2006, which is why we are very much concentrating on this area.

**Mr Davidson:** Might I invite the minister to meet me to discuss some science papers that I offered to the previous incumbent of his illustrious position?

**The Convener:** I am sure that the minister has noted that generous offer. I call Shona Robison.

**Shona Robison (Dundee East) (SNP):** My question was on the new regime, but it has just been answered.

**Mike Rumbles (West Aberdeenshire and Kincardine) (LD):** Would you agree, minister, that a safety-first principle must always be upheld in food health, and that that is a fundamental principle? Do you agree that, if there was regime change in this area, we would have to be very careful? If such a change resulted in any change to the safety-first principle, and if something went wrong, then the industry would be damaged.

**Mr Kerr:** I agree totally with that. That is why, in the debates that we have held in the Parliament, we have been so tied to that policy. If we were to let it go, we would have a serious problem, not just for scallop fishing but for all food procurement and food consumption and it would result in people losing faith in the system that we adopt to protect them. That principle is fundamental to our approach. When it comes to protecting public safety, I do not like to second-guess those who are at the front line and who are working with the directives as they currently stand.

**The Convener:** If there are no further questions, and if no member wishes to debate the order, I invite the minister to move motion S2M-1811.

*Motion moved,*

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No. 10) (Scotland) Order 2004 (SSI 2004/412) be approved.—[*Mr Andy Kerr*.]

**The Convener:** The question is, that motion S2M-1811 be agreed to. Are we all agreed?

**Members:** No.

**The Convener:** There will be a division.

**FOR**

Eadie, Helen (Dunfermline East) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

**AGAINST**

Davidson, Mr David (North East Scotland) (Con)

**ABSTENTION**

Robison, Shona (Dundee East) (SNP)

**The Convener:** The result of the division is: For 6, Against 1, Abstentions 1.

*Motion agreed to.*

## Community Health Partnerships (Scotland) Regulations 2004 (SSI 2004/386)

## Mental Health (Advance Statements) (Prescribed Class of Persons) (Scotland) Regulations 2004 (SSI 2004/387)

## Mental Health (Patient Representation) (Prescribed Persons) (Scotland) Regulations 2004 (SSI 2004/388)

## National Assistance (Assessment of Resources) Amendment (No 2) (Scotland) Regulations 2004 (SSI 2004/389)

## Food Safety (General Food Hygiene) Amendment (Scotland) Regulations 2004 (SSI 2004/394)

## Food Safety (Act of Accession concerning the Czech Republic and other States) (Consequential Amendments) (Scotland) Regulations 2004 (SSI 2004/395)

## Mental Health Tribunal for Scotland (Disciplinary Committee) Regulations 2004 (SSI 2004/402)

**The Convener:** We will now deal with seven items of subordinate legislation that are subject to the negative procedure. The Subordinate Legislation Committee had no comment to make on the Food Safety (General Food Hygiene) Amendment (Scotland) Regulations 2004 (SSI 2004/394), the Food Safety (Act of Accession concerning the Czech Republic and other States) (Consequential Amendments) (Scotland) Regulations 2004 (SSI 2004/395) or the Mental Health Tribunal for Scotland (Disciplinary Committee) Regulations 2004 (SSI 2004/402).

Members have received a paper containing the comments that the Subordinate Legislation Committee made on the Community Health Partnerships (Scotland) Regulations 2004 (SSI 2004/386), the Mental Health (Advance Statements) (Prescribed Class of Persons) (Scotland) Regulations 2004 (SSI 2004/387), the

Mental Health (Patient Representation) (Prescribed Persons) (Scotland) Regulations 2004 (SSI 2004/388) and the National Assistance (Assessment of Resources) Amendment (No 2) (Scotland) Regulations 2004 (SSI 2004/389). No comments have been received from members of this committee, however, and no motions to annul have been lodged in relation to the instruments.

Are we agreed that the committee does not wish to make any recommendation in relation to the seven instruments?

**Members** *indicated agreement.*

# Work Force Planning Inquiry

14:13

**The Convener:** We now move on to our work force planning inquiry. We have two panels of witnesses. The first panel comprises Tom Kelly, chief executive of the Association of Scottish Colleges, Riona Bell, director of funding for the Scottish Funding Councils for Further and Higher Education, and Professor Jim McKillop, head of the undergraduate medical school in the University of Glasgow.

We have written evidence from our witnesses, so I suggest that we start questioning straight away. That is what we normally do.

**Mike Rumbles:** I want to focus on dentistry, which is a major problem in Scotland. For instance, this morning, Grampian NHS Board announced that it is looking for 10 new dentists to work in the national health service. Scotland faces a crisis because of the lack of NHS dentists—use of the word "crisis" does not over-egg the pudding. The written evidence from the Scottish Funding Councils for Further and Higher Education and from Universities Scotland both focused on dentistry.

The submission from the SFCFHE says that undergraduate dentistry is a controlled subject, based on direction from the Scottish Executive. It states that, for the year 2004-05, the Scottish Executive wanted the output target of 120 qualified dentists to be increased to 134. I appreciate that the dates involved are different, but the Universities Scotland submission says that there were, at the last count, 95 graduates of clinical dentistry. I would like to know what accounts for that apparent discrepancy. In any case, do you believe that moving from 120 students to 134 is good enough to satisfy the public demand for access to NHS dentistry? Are we on the right track? Whose statistics are right? Are we going in the right direction? Are we going far enough? It does not seem to me that we are.

**Riona Bell (Scottish Funding Councils for Further and Higher Education):** Our figures are taken from our main grant letter for 2004-05. In calculating the funded places, we start with an output target and include assumptions about survival rates between input and output in order to take account of students who drop out of the course. If we base our calculations on the average history of survival rates, we can work back to intake and arrive at figures for each year of the five-year course, which are added up to make the funded places. Our statistics therefore refer to the numbers of people who are currently in training.

We increased places between 2003-04 and 2004-05 by the number that the Scottish Executive Health Department suggested; we are the instrument through which the department's decisions on work force planning are implemented. I cannot explain the figures in the Universities Scotland submission.

14:15

**Professor Jim McKillop (University of Glasgow):** I cannot explain the figures directly either, but I agree with Riona Bell and I think that the figure that Mike Rumbles mentioned refers to graduate production in a particular year. It would be interesting to identify whether the figure is a one-off, because there are different drop-out rates in different years. I suspect that that might be an issue. However, I am not directly involved in dentistry.

**Mike Rumbles:** If we accept that the number reflects drop-out figures, is the Scottish Executive providing the right information and are the institutions responding in the right way? You might know that there used to be three dental schools in Scotland. There are now two dental schools and an outreach centre is being established in Aberdeen. How many graduates were we producing 10 years ago? According to the figures in the submission of the Scottish Funding Councils for Further and Higher Education, we are producing 134 graduates—only 14 more than previously. Are we responding effectively to the crisis?

**Professor McKillop:** I do not know what production was 10 years ago, but there was certainly a period when it was thought that fewer dentists would be required because of fluoridation, for example. We now realise that that is not the case.

As Riona Bell said, the response of the universities is to train the numbers that the Scottish Executive Health Department states are needed. We are involved in discussions with the department about what the numbers might be, but at the end of the process we have to train the numbers for which the Executive provides funding.

**Mike Rumbles:** Basically, are you saying that you do what you are told by the Scottish Executive?

**Professor McKillop:** Not entirely. I cannot speak directly for dentistry, but I can speak about medical student numbers; we are firmly involved in the debate about what the appropriate numbers of them might be. However, at the end of the debate, the Executive takes the decision.

**Mike Rumbles:** What do you think the appropriate numbers are?

**Professor McKillop:** Do you mean in relation to dentistry? I do not know, because I am not involved in dentistry.

**Mike Rumbles:** Does Riona Bell have any idea?

**Riona Bell:** No.

**Mike Rumbles:** I would like a written response on the matter, if that is possible.

**The Convener:** I recall that we might hear from witnesses who can speak specifically about dentistry later in our inquiry—I am not sure about that, but we can dig out the information for Mike Rumbles.

**Mr Duncan McNeil (Greenock and Inverclyde) (Lab):** Given the questions that have been asked, it would be useful if Riona Bell could explain briefly the role of the Scottish Funding Councils for Further and Higher Education in the process, in relation not just to numbers in dentistry but to the health-professional work force as a whole.

**Riona Bell:** We control the number of students who are taught in higher education institutions, but that number is given to us by the Scottish Executive Health Department. We take part in discussions with the department each year to determine the intake for the year and our funding methodology reflects the figure that is determined. We give a number of funded places to the institutions that have medical and dental schools and we then control those numbers by means of funding, which is the only positive control lever that we have. We give funding and we attach conditions to funding.

The condition that we attach is that if the institutions under-enrol beyond a certain tolerance, we will claw back the funding for those places beyond the tolerance. Equally, we can apply penalties if they over-recruit. The reason why is that when students leave university they go into further clinical training, so we need to ensure that places are available and that those places are funded.

**Mr McNeil:** That is helpful, but it also surprising that places can be oversubscribed when we have a shortage of doctors and dentists. You are talking about how doctors and dentists are allocated places. What about other health professionals? Do the rules, limits, checks and balances apply throughout the health professions?

**Riona Bell:** No. The other health professions are not controlled subject areas.

**Mr McNeil:** Is that why we have more of them but are short of doctors and dentists?

**Riona Bell:** The next witnesses will be able to tell you how the numbers are determined for other health professions. That is done between the institutions and the health service.

**Professor McKillop:** May I come in on the role of the institutions? Some of you will be aware that Sir Kenneth Calman recently carried out a review of basic medical education in Scotland to examine what would be appropriate numbers of medical students, and therefore graduates who would subsequently join the Scottish health service. The various medical schools were intimately involved in the discussions on what was possible in terms of accommodating increased numbers. One of the great problems that we have in clinical specialties is that a large part of undergraduate training involves a student's being on clinical placement, for which there are limited resources, so any increase in numbers has to be controlled and funded appropriately.

**Mr McNeil:** An additional 100 medical places have been requested. Is that realistic? Will we meet that target and will it meet demand?

**Professor McKillop:** If the 100 places were appropriately funded, the medical schools could cope and the NHS could cope with the clinical component of their training. Whether they would meet the long-term targets would depend upon the model that was being used. A variety of numbers have been quoted for the number of doctors and other health professionals that will be required by 2020—those numbers depend on the model of the health service that is used. To be honest, 100 medics would probably not meet any of the targets; that number is probably an underestimate.

However, other issues need to be addressed. One of the problems that we have in meeting numbers is in retaining graduates in Scotland, which is not principally an issue for medical schools. There is also the fact that the work pattern inevitably changes, partly because of the European working time directive and partly because of changes in the gender balance of the profession. Now, 60 to 70 per cent of our undergraduates are female—they are the bright ones who get into medical school. Maybe they also have the other skills that we need in doctors. That pattern will inevitably change the way in which the profession delivers and the way in which training has to be done. The issue is not just the number of medical students. Other issues are important in meeting target numbers.

**The Convener:** We will probably come on to some of those other issues.

**Helen Eadie (Dunfermline East) (Lab):** How can you add more value to NHS Scotland's planning strategy?

**Professor McKillop:** Value can be added in a variety of ways. One important thing is to ensure that, within the schools, we respond to changes that will happen in professional roles. The doctors and nurses of the future will not do the same things that doctors and nurses currently do. We can add value by ensuring that we prepare people for the life of change that they will enter.

We can also add value by ensuring that we train people for a fairly generic skill. In the old days, we trained medical students so that they could go out and set up their plate in an independent practice the next day. That is not appropriate now; we need people who can do a generic task and can subsequently be trained and pick up the postgraduate opportunities that are available to them. We can also add value to the NHS through the variety of biomedical and public health service research that goes on in the medical, nursing and other schools.

**Riona Bell:** The answer lies beyond pure funding and the control of funded numbers. We encourage institutions to have dialogue with the health service and to be responsive to its needs, and we have regular tripartite meetings with the institutions and the health service. That is as effective as, or more effective than, blunt funding instruments.

**Mike Rumbles:** I will focus on doctor numbers, which Professor McKillop mentioned in a throwaway line to the effect that he did not think that any of the Scottish Executive targets would be met. The European average for the number of doctors per head of population is 40 per cent higher than the figure for Scotland. The Universities Scotland submission says that we produce 1,000 doctors in Scotland per year and the Calman review says that we should produce another 100, which is another 10 per cent, so if we wanted to get up to the European average, we would need 400 more doctors per year, not 100. Is that why you say we will not meet the targets?

**Professor McKillop:** It is not the only reason; there are different patterns of health care in Europe and different patterns of what different professions do. In the NHS, we have appropriately considered extending the role of a variety of health care workers so that they can do things that might be done by doctors in other countries, so it is not only a matter of the European average. I say that because the Temple report is producing projections of medical numbers and if we examine the projections to 2020—I do not have the precise figures in front of me—they are substantially greater than 100 extra students per year. That may be one of the reasons why Ken Calman suggested in his report that those 100 students should be a first phase and that, further on, there may be a need for additional numbers.

**Shona Robison:** Are you surprised that the number of student places has remained the same for the past four years? Did you expect that the increase would have happened by now? Why has there been no increase?

**Professor McKillop:** I cannot say why there has been no increase in the numbers. There has been an impression for two or three years that we need increased numbers if we are to meet the work force projections. There is a view in Scotland that our already having more medical students per head of population than south of the border—even with the increased number of places there—may be inhibiting an increase in Scottish numbers at the moment. However, if we examine the numbers that will be required, it is clear that we need not more medical students but more doctors to be produced at the end of medical degree courses.

14:30

**Shona Robison:** Have you been asked about that or did you give any opinion about it over the past three or four years?

**Professor McKillop:** The Calman review was set up because the medical schools and the Health Department had indicated that there was a problem and that the approach to it needed to be planned. One of the other issues that we hit is that the demographics in Scotland are such that, if we recruit from the places from which doctors traditionally come, we cannot fulfil the quotas. Therefore, widening of access and participation is important and was focused on in the Calman review. However, if we are to widen access and participation, we need to consider non-traditional ways of training individuals and of getting them into medical school to start with. That has taken time to achieve.

**Shona Robison:** How does the set-up in Scotland—you receive a funding allocation and administer the numbers that the Executive tells you to administer—compare to the funding of places and the direction that is given in other European countries?

**Professor McKillop:** The situation is the same in all the United Kingdom countries, but I do not know about other European countries.

**Mr Davidson:** The matter really comes back to a point that Professor McKillop made earlier. The issue is not just about having undergraduates in health care courses; it is about the production of qualified persons in health care regardless of the profession. What influence do the royal colleges have on the thinking of the three bodies that you represent?

**Professor McKillop:** By and large, the medical royal colleges have a positive influence because they ensure that training is developed, assessed and enforced locally within national standards. There are some new issues that they will have to face, such as the generic training that doctors will undergo and how it is assessed. The royal colleges are working closely with the Postgraduate Medical Education and Training Board, which is established in England but will have a UK-wide basis, and the General Medical Council. By and large, the royal colleges are responding positively.

**Mr Davidson:** What about their influence on your university's role as a university in Scotland that is providing those courses?

**Professor McKillop:** The royal colleges influence my role as the head of an undergraduate school because I produce individuals who will feed into that system and we need to ensure that we are joined up. A number of initiatives either exist already or are on the way—especially under the banner of NHS Education for Scotland—to ensure that that joining up happens.

**The Convener:** I would like to bring in Mr Kelly. If we are not careful, we will spend all our time talking about doctors and dentists.

**Mr Davidson:** I addressed the question to all three organisations.

**Tom Kelly (Association of Scottish Colleges):** For the non-degree professionals and workers who are our main concern, institutions that set professional standards are absolutely vital. The individual student and, indeed, the employer is entitled to expect that the standard qualification will meet the current requirement for licence to practice. The mechanisms for modernising that and getting it to work differ by specialism. In our area, we are trying to take a broad approach to the work force that recognises the connections not just between NHS employment and specialised health care occupations, but between those and the wider range of occupations in personal and social care because they have many elements in common.

We want college qualifications that enable people to seek employment in a variety of areas. We want to engage more fully with the NHS so that it can use colleges to develop the lifelong learning model of training and professional development and so that it can take advantage of the fact that there are many people out there who may work for the NHS for a time but who may also work in other sectors. We are looking for freeing-up of the situation while accepting that there are certain key standards in licence to practice that we have to meet.

**Mr Davidson:** What are the funding implications if the Government decides on a number out of the blue for a specific course? Could you provide the number of places anyway?

**Tom Kelly:** Generally speaking, the college courses are one or two-year courses, so we are much better able to adjust if there is a change in demand. To be honest, the burden of getting it right often falls on the student, because colleges

are essentially driven by student demand. We do not have quotas in specific areas set by the department or the funding council. The assumption is that the colleges will make a responsible adjustment between what the students would like to do and what the employers say they will require.

**The Convener:** Are there sectors of the work force that you deal with in which, at the moment, recruitment is falling short? If so, how could that be dealt with?

**Tom Kelly:** No. The constraints are more on the supply of places. There is very strong demand for the courses.

**The Convener:** Are all the courses oversubscribed?

**Tom Kelly:** Across the country as a whole, there may be instances of a departure from that, but the national pattern is that there is increasing demand—demand that is in excess of the number of places that we can offer.

**The Convener:** So, the block is really on the number of places that are funded rather than on the number of students who wish to enrol.

**Tom Kelly:** No, the block is on the overall funding for the individual college. The college itself decides how many places of what sort it should offer. You must remember that, especially in a modern college of further education, a lot of the provision is part time. People will choose to study for a supplementary qualification or start to learn for a new field in the evenings, or whenever.

**Riona Bell:** You must also remember that a number of the courses require work practice or the equivalent of clinical placements. It is essential that, when students are taken on, the institution that is teaching them is able to give them work placements.

**The Convener:** Do you get a set amount of money for the college, which decides which courses to spend it on?

**Tom Kelly:** Yes. You are right to make that distinction. The funding council does not have a lever that allows it to put another 100 or whatever technicians in a particular area.

**The Convener:** So at that point it is entirely up to the college administration to make any adjustments that it deems necessary.

**Tom Kelly:** But the same holds true across a wider range of employment. On the whole, the system works well, because employers are not slow to say when they need more employees and students are not slow to react to new employment opportunities.

**Dr Jean Turner (Strathkelvin and Bearsden) (Ind):** After visiting some establishments, I got the impression that even if there were more funding and more students universities would still not have the capacity to deal with them. They can deal with only X number of students in the university buildings and in the outreach clinics in hospitals, dental surgeries and so on. Am I right to suggest that that is quite a major constraint on the numbers that are going through the system?

**Professor McKillop:** It is certainly a constraint. Numbers could be increased if there were additional resources and facilities; however, existing establishments find it difficult to ensure that all students have appropriate training and experience. Moreover, in the NHS, placing doctors, nurses and so on in training slows up the clinical service. If someone is trained as they provide the clinical service—which has to be done if they are to be good clinical practitioners—that will inevitably slow things up. Arrangements have to be made to fund that area. I know that additional cost of training—or ACT—funding is available in medicine, but I do not think that the other professions have provisions that take account of the demand that the increased numbers place on the service.

**Dr Turner:** Do you have anything to do with financing hospital doctors who train medical students?

**Professor McKillop:** Yes. ACT funding is an estimate of how much it costs the health service to have medical students in hospitals and practices and in other community placements. That money flows to the health boards and what used to be the trusts in proportion to the amount of training and teaching that they carry out. That said, there is an issue of transparency around how that money is used. For example, it is often difficult to trace whether it has been used for educational purposes rather than for underpinning a clinical service.

**Dr Turner:** So we need to pay particular attention to that matter.

**Professor McKillop:** Yes. NHS Education for Scotland, which has taken over responsibility for that area, thinks that transparency is a very important issue.

**Kate Maclean (Dundee West) (Lab):** When the convener asked whether levels in some areas of recruitment were falling short, I was surprised to hear Tom Kelly say that all the courses were oversubscribed. Does that mean that there is a high drop-out rate? If so, do you lose more students in certain areas than in others?

**Tom Kelly:** I must apologise as we have not carried out any research into that matter. However, we can do more analysis of the numbers if that would be helpful.

**Kate Maclean:** I am just surprised to find that, although the courses are oversubscribed, there are shortages in certain areas. I would be interested to see a breakdown of those figures.

**Tom Kelly:** We will try to provide that.

One of the key points about the college sector is that although a lot of people might take a course they might not find their job of first preference. We need to watch that mismatch very carefully. The limited number of placements is also a constraint. We can carry out a certain amount of simulation of practical elements without putting people into clinical situations, but that is expensive. As I have said, we can take a look at the matter.

The problem for the colleges is that the sector covers myriad elements, all of which are quite complex and perhaps small scale at the level of the individual college. That said, we will see what information we can find for you.

**Kate Maclean:** If someone who undertook a further education or access course moves on to higher education, would that be recorded twice?

**Tom Kelly:** It should not be.

**Kate Maclean:** So those people would not be recorded as being in further education. They would be recorded as a higher education statistic.

**Tom Kelly:** Yes; if they do a higher national course, they will be treated as a first entrant to higher education at college, but they would be treated as a continuing student if they went on to do a degree course, as well they might.

**The Convener:** We need to move on. I am conscious of some of the evidence that we have had that suggested that the issue is often not so much about the number of students but about the numbers of those who get to the end of their course and then go on to work in the NHS in Scotland. The British Medical Association tells us that something in the region of half of all medical students in Scotland do not go on to work in Scotland, which will also have a big impact. I know that several members of the committee want to raise questions about that.

**Janis Hughes (Glasgow Rutherglen) (Lab):** As has been said, the Calman review recommended that one way of increasing the size of the medical work force in Scotland was to do more to encourage Scottish students to enter Scottish medical schools. I believe that students from the University of St Andrews did their placements in Manchester—certainly it was somewhere in the south. I know that that arrangement was being examined but I am not sure whether it continues. Do you have evidence that such situations encourage students to pursue work south of the border when they become registered?

**Professor McKillop:** The figures in the Calman report show that the retention in Scotland of medical graduates is lowest for St Andrews students. It is difficult to disentangle whether the fact that the students go to Manchester is the issue, because many of those students will not have been domiciled in Scotland when they entered the course. There is also evidence in the Calman report that the students who are most likely to stay in Scotland are those who were domiciled in Scotland when they started the course. As I said, the St Andrews figures are quite difficult to disentangle but I suspect that the Manchester placement—the students spend the final three years of their course in Manchester—is a significant factor, and that the situation will continue at least for a spell.

**Janis Hughes:** Is the arrangement still in place?

**Professor McKillop:** Yes.

**Janis Hughes:** Are discussions under way to change the arrangement?

**Professor McKillop:** The Executive has still to announce its response to the Calman report. However, the medical schools and associated individuals have begun to work on how we can deal with the situation. There are plans that would allow the 50 St Andrews students who are referred to in the Calman report to complete their training in Scotland. Whether that will increase the likelihood of their staying in Scotland is another issue.

**Riona Bell:** If the St Andrews students were to stay in Scotland to do their clinical training, additional clinical places would be required in the Scottish university to which they then moved on.

**Janis Hughes:** Is that likely to pose a problem?

**Riona Bell:** It is being considered as part of the Executive's response to Calman.

**Professor McKillop:** Not just places but additional funding will have to be considered. At the moment, the clinical funding for those students is covered by the English funding council.

14:45

**Tom Kelly:** The other general point that applies to what we do in colleges is that the number of years that people spend on their career is reducing, which is a problem. I do not know what the correct figures are for medicine but if, for example, the length of a career in medicine is coming down from 40 years to 30 years, the argument that people can start their careers later becomes all the stronger. We have to consider whether we have the right mechanisms in place to allow later starters to study towards entry to the profession. Colleges would definitely have a role in that.

**The Convener:** Does anyone want to come in on the subject of recruitment and retention?

**Mr McNeil:** I have a point that has been mentioned to me previously. Professor McKillop confirmed that if we continue to try and recruit in the usual areas we still will not be able to meet our quotas, even if we attracted all the young people who are qualified to go into medicine. That is a big issue and we need to look beyond the usual suspects. What about the high standards that are required for entry into medicine? Do they have to be considered?

**Professor McKillop:** I would not like to pretend that the current entry requirements are absolutely necessary to practise medicine, but I do not know by how much one could drop them. The problem is that they are the objective criteria against which one can judge applications. One could use other ways to conduct an extremely extensive assessment, but that would be expensive.

Let me give an example. My medical school receives about 2,000 applications for 240 places. Of those 2,000 applicants, it is likely that between 900 and 1,000 will meet our entry requirements. If we were to conduct extensive interviewing and all sorts of testing for those individuals, the exercise would become enormously expensive in itself.

In relation to bringing in other people, one could consider whether alternative ways into medical schools should be provided—I am thinking of access and foundation courses. Applicants for those courses might not have the traditional highers qualifications, but they achieve a similar standard at the point of entry to those who come into the medical schools by traditional routes. Work into such areas is under way.

**Mr McNeil:** Do the tough standards apply equally across all the medical schools?

**Professor McKillop:** They vary slightly, but only very slightly. The standards tend to depend on the number of applications that the school receives.

**Mr McNeil:** How do we compare with other countries that do things differently?

**Professor McKillop:** Again, it is hard to make direct comparisons because other countries work to different standards—for example, they may use the international baccalaureate and so forth. However, by and large, medicine tends to have fairly high entry criteria in other countries.

**Mr McNeil:** I asked the question because we are constantly being told that health care throughout Europe is better than it is here.

**Dr Turner:** My question goes back to the subject of capacity. As we have said, people may qualify in a subject but if there is no job for them in the city or in the rural or remote place in which they live they have to look elsewhere. Have you done any work on how the new trend towards centralisation and a reduction in the number of sites and buildings might affect people such as medical students and paramedics getting placements?

**Riona Bell:** The Calman report addressed the situation of medical students and recommended greater collaboration among medical schools and the setting up of a board for medical education. The present talks have identified that such a board would need to liaise with NHS Education for Scotland and the existing work force planning arrangements to get a more coherent view of the needs of the sector. NES looks after the postgraduate part of students' education. The member raised the issue of the need to have places for the young doctors to go to once they have graduated, which is being addressed in the sector's response to the Calman report.

**Dr Turner:** Perhaps our move towards centralisation means that we are working towards fewer places.

**Professor McKillop:** We may be working towards fewer places in hospitals. Increasingly, however, in undergraduate and postgraduate medical training, importance is placed on the community aspect of the training. The criticism that was quite rightly levelled at medical schools in the past was that we concentrated our training on hospitals. Because of that, our students did not see the reality of illness in the community. Increasingly, our training will have to look at community placements of various sorts, whether in general practice, community psychiatric care or whatever.

**Tom Kelly:** That is less of a problem for the colleges. Personal and social care tends to be needed in every community in Scotland, which means that opportunities for placements and jobs are more likely to be close at hand.

**Mike Rumbles:** I will pursue the point that Professor McKillop raised in response to Duncan McNeil, as I want to get it right. I am a lay person, and everyone tells me that there is a shortage of GPs and consultants—a shortage of doctors—throughout Scotland. You have just told us about the huge demand for places at your school. I cannot remember the figure that you quoted—

**Professor McKillop:** We get about 2,000 applications for 240 places, but that is just the picture at one university. It is likely that the individuals involved will also have applied to three other medical schools. A significant proportion of those 2,000 applicants will not meet the academic criteria. Those applicants might not meet the requirements even if they were lowered.

**Mike Rumbles:** I am trying to probe that point. I understand that your figures relate to a particular university, but the general impression is that it is difficult to get into medical school because academic standards are high. However, students undergo many years of training and people mature at different rates. We are told that there is a shortage of doctors, but you tell us that there are huge numbers of people who want to be doctors and you can offer only so many places. Do you see what I am getting at?

**Professor McKillop:** Yes. I touched on the matter when I said that I do not think that the current academic requirements are absolutely necessary for someone to become a successful medical student and doctor. However, they are the objective criteria that we have, given that we have a limited number of places. If additional places were available, a variety of individuals could be brought into medicine.

**Mike Rumbles:** Are you saying that it is not the case that there is no demand for places at medical school; there is a real demand and people want to train to become doctors?

**Professor McKillop:** Yes.

**Mike Rumbles:** How can we effectively train people who might not meet your current standards at the point of application? Surely everything in life tells us—the education system tells us—that people mature at different rates.

**Professor McKillop:** Absolutely. The idea that more mature or graduate entrants might be brought in from elsewhere is important. However, postgraduate training, particularly in medicine, is quite long. Someone who wants to become an NHS consultant might train for up to 10 years after graduation. If people start training when they are substantially older, their working life of service to the NHS might be significantly shorter, so we run up against a problem at the other end of people's careers. We perhaps cannot extend mature entrance indefinitely, although many mature entrants can certainly enter medicine.

**The Convener:** The number of funded undergraduate places would have to be increased to allow you to recruit more students.

**Professor McKillop:** Yes.

**Mike Rumbles:** The demand is there.

**Shona Robison:** Professor McKillop said that 900 to 1,000 applicants to the medical school at the University of Glasgow meet the requirements—

**Professor McKillop:** I said that that number of applicants is likely to meet the requirements.

**Shona Robison:** How many of those 900 to 1,000 applicants do not get a place in undergraduate training in Scotland?

**Professor McKillop:** I do not have precise figures. However, across the UK, if someone meets the entry requirements for medical schools they are, by and large, likely to be able to secure a place.

**Shona Robison:** It would be useful to know how many applicants who originate from Scotland do not secure an undergraduate place in Scotland, given that people who train in Scotland are more likely to stay in Scotland. Could you obtain those figures for the committee?

**Professor McKillop:** I am sure that we can find those figures. However, we must accept that some people from Scotland choose to attend an English medical school; they do not go to England just because they cannot—

**Shona Robison:** I am talking about people whose first choice is a place in Scotland.

**Professor McKillop:** Students apply to four medical schools, but we do not know which is their first choice. That is one of the problems with applications.

**The Convener:** Can you give an indication of the relationship between the universities and the royal colleges in relation to the setting of postgraduate standards for medical specialisms and the identification of training places?

**Professor McKillop:** The relationship was not always easy in the past and there was a bit of a turf battle. However, that has not been a major issue during the past 10 or 15 years. There is much more talk about the role of the undergraduate schools and what undergraduate study leads into. That is partly because we are now under the influence of the General Medical Council, which published a document about 10 years ago entitled, "Tomorrow's doctors: Recommendations on undergraduate medical education". The document stated that by the end of their undergraduate training, the student should be a generic practitioner with a wide range of clinical and other skills, who will subsequently undertake an appropriate period of training in a postgraduate sphere that allows them to specialise in a discipline. That approach appropriately and helpfully separated the roles of the undergraduate schools, the medical royal colleges and the postgraduate deans. We are now clearer about where our boundaries are and where we can join up without duplicating activity.

**The Convener:** Can you comment on that issue in relation to postgraduate courses for allied health professions?

**Professor McKillop:** Not directly, I am afraid.

**The Convener:** Can anyone on the panel comment on that?

**Tom Kelly:** Not at postgraduate level.

**Riona Bell:** That question is for the subsequent panel.

**Tom Kelly:** I have a comment that probably applies at the lower levels. It is important that professional institutions that are not Scottish based are willing to accept and recognise our Scottish qualifications framework as providing levels and credit, otherwise we will not have flexibility in professions in which an institution controls licence to practise. We are working on that matter. At present, we generally work case by case through the Scottish Qualifications Authority for our provision, but we need to have that flexibility.

**The Convener:** I have a general question for any of the witnesses. On the issues on which you have been questioned, are you aware of the analogous situation in other countries? For example, are there figures on recruitment and retention in other countries? What is the equivalent figure in other countries for those who graduate and then leave the profession? We would appreciate receiving such information.

**Tom Kelly:** There is evidence from the United States that most of what are called there the first responder professions—

**The Convener:** What does that mean?

**Tom Kelly:** It means firemen, policemen and medical workers. Most of them have qualifications from a two-year associate degree. About 60 per cent of all new nurses in the United States have associate degrees. Those two-year college-based qualifications apply to a much wider range of public services than, for example, the higher national diploma in Scotland does. That is an example of a degree that is offered at local colleges rather than state universities and which is deliberately pitched at a wide range of professions.

**Professor McKillop:** In the other countries in the UK, the number of individuals who leave medicine for other jobs is similar. The figures for countries in the European Union are varied, which may be related to the ease of obtaining employment. In some EU countries, there are more doctors than work, so people do other things, whereas in other countries where there is a shortage of doctors, there tends to be a high rate of employment.

**The Convener:** Are you saying that in certain EU countries there are more doctors than can find employment?

**Professor McKillop:** Yes. For example, Italy has large numbers of medical graduates who are either unable to obtain employment or who can obtain only part-time employment.

**The Convener:** That is interesting.

**Mr Davidson:** I have a quick final question. There seems to be a correlation between the number of postgraduate opportunities and the number of undergraduate places. We have heard in evidence that the undergraduate positions are under the influence of the funding council and the Scottish Executive. What is the connection with postgraduate places? Professor McKillop mentioned the health boards and money not necessarily being where it ought to be.

**Professor McKillop:** That was at undergraduate level.

**Mr Davidson:** What about the postgraduate level? There is a connection.

**Professor McKillop:** The number of available postgraduate training posts is controlled centrally by the postgraduate deaneries and the body that is now called NHS Education for Scotland. In a sense, that number is constrained by the likely number of graduates that will come through. There is a link: for example, the number of pre-registration house officer posts—for the first year after graduation—is dictated largely by the number of graduates. People need those posts to get full registration with the GMC and to proceed to the next step of training. The two are strongly, although not absolutely, linked.

**Riona Bell:** That is why the funding council cannot change the number of undergraduate places unilaterally. We must ensure that the number is joined up with the number of postgraduate training places, which is why we have a tripartite planning arrangement. We will work through that issue in our response to the Calman review.

**The Convener:** In the past 45 minutes, the witnesses have indicated that they could provide further information to the committee—we would appreciate that. I thank the witnesses for their evidence.

We will have a short break of about five minutes to allow folk to get coffees or teas or do whatever they want to do.

15:01

*Meeting suspended.*

15:07

*On resuming—*

**The Convener:** I welcome the second panel of witnesses and thank them all for attending. They are James Kennedy, director of the Royal College of Nursing Scotland; Bridget Hunter, lead officer for nursing, Unison Scotland; Christina McKenzie, head of midwifery, the Nursing and Midwifery Council; and Professor Jack Rae, dean of the school of health, nursing and midwifery at the University of Paisley. We have received written submissions from the RCN, and the Universities Scotland submission also applies to the panel.

**Janis Hughes:** The Scottish Executive partnership agreement commits the Executive to training, recruiting and retaining an additional 12,000 nurses and midwives by 2007. What are your views on those targets?

**Professor Jack Rae (University of Paisley):** The targets are quite challenging for the providers, but they are probably achievable. The main constraint on most of us is clinical practice placements, for which we agree numbers with our clinical colleagues.

What is interesting, in terms of quality, is that we often say to the Scottish Executive that we cannot take any more students than the normal intake stream because there are difficulties in maintaining clinical practice placements. However, recent initiatives short-circuit that to some extent. They include higher national certificate preparation in further education, after which the student enters into year 2 of training, which means that there is then a two-year move to qualification, and the use of the Open University package with higher education institutions as providers, which means that people in remote and rural areas who could not otherwise be trained can now be trained and continue to live in their area.

I think that the target is achievable, but it is an intake target: the output is something different.

**James Kennedy (Royal College of Nursing Scotland):** From our point of view, the words in the partnership agreement are particularly interesting. Having discussed the matter with the then Minister for Health and Community Care and his officials, I know that the figure of 12,000 is, in essence, a recruitment target. The Executive needs to do very little to achieve that target, whereas some of the other targets in the partnership agreement are about growth. The partnership agreement does not build up any specific growth in the nursing work force at a time when we know that, for example, changes in out-of-hours provision, the consultant contract, the development of school nursing and some increased annual leave that is associated with agenda for change, will lead to an increased need for more nurses in Scotland.

A balance must be struck between retention of the existing work force and recruitment. In that context, issues such as flexibility about pensions become really important in relation to the retention of nurses, in particular those who are getting older. The Joseph Rowntree Foundation has done some good work that reinforces good models that I think we could consider here in Scotland and which would help us to retain more nurses than it looks like we are doing currently.

**Bridget Hunter (Unison):** Professor Rae mentioned HNC entry, which Unison considers to have been a great success. There has to be some out-of-the-box thinking about how we bring people into the profession, because the academic qualifications have perhaps restricted recruitment. Unfortunately, we have accelerated that in some ways. I would hope that the opportunities that have been gained from support staff coming into nursing through the HNC route would assist. The numbers would increase if we were to think of other ways of bringing people in.

**Janis Hughes:** That is an interesting point; I was going to ask the panel what else we could do to encourage people to consider nursing as a profession in the first place.

I was interested in the following comment in the Royal College of Nursing's submission:

> "If retention levels are to be improved, nursing must be made an attractive profession for new entrants."

Nowhere in the paper, though, do you consider any other routes to nursing, for example by allowing people to enter the profession on a salaried basis. I am keen to consider a non-academic route to nursing, because we are disenfranchising a huge number of people who would make excellent nurses. Do you have other ideas about how we can make nursing a more attractive profession?

**James Kennedy:** Yes, indeed. As you know, the former Minister for Health and Community Care, Malcolm Chisholm, chaired an important partnership—the facing the future group—of which colleagues are all part. That group has very much taken up the mantle of considering the recruitment and retention of nurses in Scotland. One of the issues that we have considered is the situation with health care assistants, who are clearly attracted to care and some of whom are keen to enter nursing. Work is going on to support health care assistants in moving into pre-registration nursing courses, and development work is going on in Glasgow, particularly in primary care, in relation to that. We very much support those alternative paths.

We believe that the implementation of agenda for change, which will set out a new career framework for a significant number of NHS staff—including, but not exclusively, nurses—will give a good career path over time. The RCN's view is that we have got to make the profession more attractive. Equally, we have got to make it attractive to those who are currently in the profession. We have an attrition rate among our Scottish students. During training, we lose about 22 per cent of students and a number of students, even when they qualify, do not register to nurse. Another proportion do not register to nurse in Scotland but move elsewhere. There is a major challenge of holding on to those that we have got, as well as widening the entry gates. Some of the work that is being done in the facing the future group is beginning to take effect.

The committee has highlighted the issue to us previously. Jack Rae might want to say a bit more about it.

15:15

**Professor Rae:** Perhaps I could say something about salaried places, which the committee has spoken about. I agree with much of what James Kennedy said.

Way back, we were salaried, and we were used as part of the work force; as a consequence, we were not educated properly. As a result of that, we have become supernumerary. Janis Hughes suggested salaries, but a lot has been done with the non-means-tested bursary, which is a lot better than it was; there is much better support for individuals than there has been in the past. More thought and investment are required. Something that might be worth considering is making student loans available to nursing students. If the student went on to work in the NHS, the loan would be paid for by the NHS. In that way, many people would be retained and they would not be exposed, as was previously the case, to being seen as pairs of hands in areas where there is a great deal of pressure and where, of necessity, patients come first.

**Mr Davidson:** The RCN submission suggests that 11.9 per cent of nurses who qualify in Scotland do not register. Has any work been done on that? Is there an opportunity to do something about that issue?

It has been suggested that retention would be improved by providing access to continuing professional development. As the RCN submission points out, the Nursing and Midwifery Council requires that nurses receive 35 hours of proper CPD over three years. I am puzzled, therefore, that the RCN seems to be content to demand three days' support per year. That does not seem to match what the council insists on.

**James Kennedy:** Mr Davidson highlights an important point. As a minimum, we need consistent gathering of data across the United Kingdom to enable us to compare like with like so that we can better determine what happens to nurses who train in Scotland but who then choose to go elsewhere. We are working closely with the NMC in considering how a common database might be established. We recommend to the committee that the four health departments ensure that they can compare like with like. The fact that student attrition rates are calculated in different ways across the UK provides an opportunity for fudge rather than for meaningful debate or solutions. From our point of view, that is an important issue.

Continuing professional development has been highlighted as a key issue in our "right for nurses, right for patients" campaign and in our submission. Research on why nurses leave the profession shows that lack of CPD is a key issue. As a minimum, nurses should have three days of guaranteed CPD with backfill and with time out from clinical areas. The midwifery profession has much more significant provision for supervision, which is built into statute. Ultimately, it would be great if we could achieve similar provision for nurses, but three days is a modest and manageable step along the way that would improve retention.

**Bridget Hunter:** I agree with Janis Hughes's suggestion that we must continue the debate on whether people can enter the profession on a salaried basis. Without doubt, student attrition rates are linked to the fact that there is real poverty out there. Some nursing students have to work in two or three different jobs to maintain themselves, but they might also be single parents who have other pressures. If we are to be realistic about finding a solution, we need to take that on board.

The financial aspect might not be the only reason for our losing nurses—students in professions allied to medicine are in exactly the same boat, even though they receive student grants—but the attrition rates problem cannot be solved until we start to consider that aspect. As well as improving the salary potentials, we need to consider ways of rewarding nursing students for the work that they do. We need to recognise that nursing students are different from other university students, in that they are required to do placements during holiday periods and so have fewer opportunities than other students have to work for money. If we want to retain them, we need to provide ways to make that possible for them. That issue needs to be taken on board.

**Christina McKenzie (Nursing and Midwifery Council):** The Nursing and Midwifery Council is reviewing the standards for continuing professional development. The requirement for 35 hours of CPD over three years is seen as a minimum, but that is likely to become more robust in the near future.

**Shona Robison:** On the figures for the growth in the work force, the RCN's submission states:

"the Scottish Executive's recruitment target of 12,000 nurses and midwives will merely be filling the gap that staff turnover and nurses leaving the NHS are creating, rather than contributing towards the necessary growth in the NHSS workforce."

The previous paragraph in the submission, which contains some interesting figures, ends by stating:

"Based on Scotland's average annual percentage growth of 0.4%, it would take until 2010 for the nursing establishment to be growing at the same rate as England's."

Why is that? What is England doing differently that contributes to its higher growth rate?

**James Kennedy:** There are a couple of fundamental differences. Until the facing the future working group was established, England was very much ahead of us in recruitment and retention strategies. Some things that England has done in overseas recruitment have, rightly, been criticised, because they have perhaps not been done ethically enough. However, the major emphasis has been on growing the core establishment of nursing. There has been real growth in investment in England, whereas the partnership agreement proposals are primarily about the status quo and involve very modest growth. That is why there is such a significant difference.

**Shona Robison:** Are you saying that England has been more ambitious with targets for the core establishment of nursing?

**James Kennedy:** That is correct. One key element that we have highlighted in our submission is a piece of work on the work load of nurses that was led by facing the future. Each health board is making proposals that will begin to address the increased work load of nurses. We believe that that work will provide us with a much better-informed basis for determining how many more nurses we need. We hope that it will put us in a position to grow even more than we are growing at the moment. In the meantime, the major emphasis must be on retention. However, the Department of Health in England has invested much more significantly in growth, as opposed to maintaining a steady state. That is related to service changes.

**Shona Robison:** We would appreciate it if you would send us some back-up material.

**Mike Rumbles:** I want to pursue this point. In his answer to Janis Hughes's first question, Professor Rae referred to the partnership agreement target of an additional 12,000 nurses and midwives as "challenging", but James Kennedy takes the opposite view—he referred to the "status quo". I am interested in that contrast. I do not have the words of the partnership agreement in front of me, but I recall that it says that the 12,000 nurses and midwives are additional. Is that not the case?

**Professor Rae:** I understand that the figure of 12,000 is an intake target and is about supply to the pool. That is challenging but achievable. At the end of my answer, I said that the target does not indicate what happens to the work force. James Kennedy picked up that point. The question is whether 12,000 is enough, and I suspect that it may not be. Something even more radical is needed.

I listened to the earlier discussion about how many doctors are needed for X, Y and Z. It might be useful for us to examine the skill mix of the work force and how many staff of each type are needed. I am not entirely sure that identifying that doctors do what doctors have always done is the answer to the problem. Part of the solution is to examine what doctors do—and what only doctors can do—and what nurses do. Nurses and other allied health professionals now prescribe. There are diabetes nurses, specialist nurses and midwife-led units. Part of the solution for the future must be to do more than focus on one group or another in isolation. They need to be examined together.

**The Convener:** Does Mike Rumbles want to follow up on his question to Professor Rae? James Kennedy would also like to comment.

**Mike Rumbles:** I would like to ask a further question before James Kennedy responds. You are saying that the focus is limited to retention. Are you saying that there is nothing wrong with the 12,000 target?

**Professor Rae:** I am saying that 12,000 is an achievable target. It does not relate solely to training, as it includes nurses and midwives who are returning to practice. The question is, is it the correct target?

**Mike Rumbles:** I return to the partnership agreement. The use of the word "additional" is interesting. If the target related solely to recruitment, the agreement would say, "We will recruit 12,000 more nurses." However, I am sure that it says that there will be an additional 12,000 nurses and midwives.

**James Kennedy:** I have a copy of the partnership agreement with me. In relation to nursing, it states:

"We will increase our programme to train, recruit and retain nurses and midwives bringing 12,000 into the NHS by 2007".

When we first read that statement, we thought that it referred to growth. However, the agreement goes on to say:

"We will aim to increase"—

there is a key difference in the word used—

"the number of consultants in the NHS by 600 by 2006",

and that

"We will ensure a total of 1,500 extra allied health professionals".

There is more than a subtle difference between increasing the number of professionals and a programme to retain staff.

I will adjust my words a wee bit. The target is not purely the status quo, but it represents a very modest growth in student intake. Initially, I and my members thought that we would get 12,000 extra nurses in the system, but when we met the Minister for Health and Community Care and his officials we found that that is not what the figure means. "Extra" means "different".

**Mike Rumbles:** I will pursue that, because I was involved in writing it.

**James Kennedy:** It is a fascinating and powerful use of words.

**The Convener:** We have to be very careful about how words are used and how they could be construed later.

**Dr Turner:** We must examine entry into the professions, but what concerns me most when I go around and speak to nurses is the existing work force. We are losing nurses because they are tired and worn out. They feel that they are not listened to and that they do not have enough people working on wards. Their clinical position is compromised. I have spoken to one or two people in recent days who would rather go and work in Asda. What are you doing to retain your qualified work force? If we cannot keep that work force because people want to get out of the profession, you will have great difficulty in getting people into it. What are you doing to improve that situation?

**Bridget Hunter:** I commend the work that has been done by facing the future. We are on that group, but we are not patting ourselves on the back. Some good, innovative ideas have come forward about how to retain staff and remove some of the workload stress. Some thought has been put in on how to do that, but it will not happen tomorrow. A massive amount of work needs to be done throughout the NHS—and it should not concentrate only on nursing. Everyone tends to look at nursing, but we must consider all the professions that contribute to the NHS, not just medics and nurses. Many of the contributions from the professions allied to medicine have assisted with staff retention. There has been some development, but clearly there must be more. There must be opportunities for the professions to grow, and more multistrata working must be developed. There are pilot schemes on that. I understand that there is one in Dundee to examine how allied health professionals can be brought in as helpers and be developed and integrated into the work force to assist with tasks. The Open University is involved in that work, as well as some of the local universities. It is not just about delegation from doctors, but about how we can share tasks better among the work force. Where there are positive gains, there must be support from the likes of the Scottish Parliament. Unison is also looking to support anything that comes from that.

15:30

**James Kennedy:** I have read the transcripts of your visits throughout Scotland, Dr Turner, and sadly, many of the messages you heard resonate with me as someone who also meets a lot of front-line nurses. I agree with your assessment that many nurses are exhausted and wonder whether it is worth their while to continue. Other options seem more attractive; they can go and work somewhere, albeit for a lower rate of pay, where they can go in, work and leave. That is one of the reasons why NHS 24 has been successful in recruiting nurses throughout Scotland; that should have been a wake-up call to NHS employers.

We mention in our evidence the introduction of appropriate—that is an important word—nurse to patient ratios. We believe that that can begin to address some of the significant work load issues because that is one of the biggest factors. As I mentioned earlier, there is now good evidence—facing the future is beginning to look at it—on how we can retain older nurses.

Another key issue is the effective implementation, not just in words but in spirit, of the agenda for change, which affects a significant number of NHS staff, not just nurses. Issues remain to be resolved, but in essence the general view of agenda for change is that it gives us enough to get on with. The work that is implemented needs to include practice nurses employed by general practitioners, who might not necessarily benefit from having agenda for change as a baseline for their employment terms and conditions. That would help to stabilise the work force.

Finally, we need significant leadership from the Executive and the Minister for Health and Community Care through their continued support for facing the future. As of last week, each health

board had to submit to the Executive a plan containing about 20 action points that address the increasing workload of nurses. If those plans are implemented there will be changes, but the work must happen quickly, because some nurses look jealously at the real growth in the work force south of the border—that relates to Shona Robison's question. Nurses talk to colleagues at UK-wide events who tell them that life is getting a bit easier because there are more staff on the wards. That is still not the case in Scotland.

**Professor Rae:** Clinical conditions are particularly important to people who are in training. Throughout Scotland there are areas where there is tremendous pressure on clinical practice and students receive less supervision, so the learning environment in practice, which constitutes half of nursing training, is not sufficiently good. That is a significant factor in wastage before people qualify and means that when students qualify they look for employment elsewhere. There are good areas in Scotland and we can identify boards whose budgets are in balance and whose staffing levels are at a particular level. To echo what Jim Kennedy said, such boards are in a position to invest in continuing professional development. It is important that although medical and dental additional costs of teaching—ACT—funding is in place for medical and dental staff development, there is no equivalent funding for nurses or allied health professionals, most of whom pay for their own continuing professional development.

**Helen Eadie:** The RCN submission says that there is a

"lack of a formal networking group or forum for workforce planners"

and goes on to mention regional work force conventions. Will James Kennedy expand on that?

**James Kennedy:** There are a few key issues. A consistent approach to work force planning is needed throughout Scotland. There are benefits in a regional model, but such a model would have to be built up from local need. Nurse managers in the NHS, who are the main providers of information to the Executive about the number of new nurses that will be required over the next four or five years, tell us that there is often no support infrastructure to enable them to make well informed decisions, rather than guesstimates. In the United States, for example, there are more sophisticated ways of identifying longer-term health care staffing requirements. During the next 10 years, the US will need a million additional nurses. That figure is primarily based on well researched work that shows increasing evidence of a connection between the number of registered nurses and the quality of patient care. There is more and more evidence of that. We are pleased that there are now nurse directors in each NHS board in Scotland, who have a key lead role in that work.

The current model in Scotland is that we have seven educational institutions, which take X number of students. The Scottish system is getting smarter at matching with local need the number of students that it is agreed are needed, so that three years down the line students go where the demand is.

**Mr Davidson:** I wanted to put a supplementary question to Christina McKenzie. What negotiations has the Nursing and Midwifery Council had with health departments around the UK, including the Scottish Executive Health Department, about the impact of stepping up CPD requirements, not just on cost, but on the capacity of the system? Will the new approach deter some nurses from sticking in nursing?

**Christina McKenzie:** There are two issues. First, the NMC is examining the matter, but has as yet made no decisions. As part of the council's usual process, there is open dialogue with all the stakeholders in the country concerned as work develops. In this case, all four countries of the UK are involved. The Scottish Executive Health Department will be fully consulted and involved in discussions as they proceed, so that the council can understand the implications for Scotland.

Secondly, the member asked whether nurses and midwives would be put off by the new approach. I return to the point that James Kennedy made about funding and support for CPD for nurses and midwives, rather than the amount of CPD. Members of both professions would be keen to receive increased support for CPD so that they can maintain their registration and competence. At present, a lack of support is causing them problems.

**Mr Davidson:** Are you referring to a lack of support from Government?

**Christina McKenzie:** There is a lack of support from employers and departments.

**Professor Rae:** I am not sure whether this is particularly helpful or whether it relates directly to the current situation, but when a form of preparation called P2000—the 1992 scheme—was introduced there was a debate about the costs of the scheme and of CPD. Essentially, it was said that both were expensive and that we could have one or the other, but not both. Undoubtedly, it is extremely costly to give a large number of staff supported time for CPD, and nurses are the largest single group of staff. I understand that cost was one of the major factors in the debate about P2000 and CPD. One of the points made was that if a nurse wanted to evolve and develop and a midwife wanted to stay on a register that was their responsibility; they had to

do the work in their own time and at their own cost. If the issue is readdressed and some allowance is made, people will be supported and CPD will become less onerous.

**Mr Davidson:** Would some of the panellists like to provide us with a little more information on the issue?

**The Convener:** We are always grateful for additional information.

I have some questions for Christina McKenzie. Paragraph 6.2 of the RCN's written evidence concerns the problem of non-registering nurses—nurses completing their course but failing to register with the college. The submission indicates

"that the number of new entrants to the register is no longer presented on a four country basis."

That means that we no longer have specific information about Scottish nurses. There is concern about that. First, what work have you done on non-registration in total—why people do not register? Secondly, why is the information no longer provided on a four-country basis? It is important from a Scottish perspective to understand what is happening with Scottish nurses.

**Christina McKenzie:** I will answer the second question first. We can and do provide information on a four-country basis. For example, the number of nurses and midwives on the register in Scotland for 2004 is approximately 64,000. We can give that information.

**The Convener:** The figure does not relate to non-registration, which is the issue.

**Christina McKenzie:** That is correct. We do not have that information, because the number of places for students beginning courses is commissioned by the health departments and through the universities. The Nursing and Midwifery Council does not have a mandate for work force planning. Our mandate is to protect the public, through setting the standards for inclusion on the register. We have no control over the number of student places commissioned, and therefore cannot comment on that.

**The Convener:** So you can provide no breakdown of comparative non-registration in the four countries.

**Christina McKenzie:** No.

**The Convener:** I ask James Kennedy briefly to comment on that, which the RCN raises in its written evidence.

**James Kennedy:** I am reassured that the NMC will continue to provide some data on a four-country basis, because that is critical. Our submission has identified a gap between the data that are collected by health departments and what happens at the point of completion of a programme. That is why we say that further research on our students, using a common data set, must be done on a four-country basis, right through to the point of registration or non-registration. If such research were done, we would be able to compare like with like. That is critical, because we have anecdotal evidence that a number of Scottish nurses are moving south of the border when they qualify.

**The Convener:** So we are not following any of it to find out exactly what the problem is between whoever might be ultimately responsible. We cannot follow the non-registered down to find out what is going on.

**James Kennedy:** That is correct.

**The Convener:** The Nursing and Midwifery Council basically sets education standards for nursing and midwifery. Can Christina McKenzie explain what setting standards means in practice? Does the NMC have the same powers as the GMC does over undergraduate medical training or is there a difference in how the two organisations operate?

**Christina McKenzie:** The Nursing and Midwifery Council is responsible for setting standards for entry to education and for the requirements for outcomes from education to enable someone to become a nurse or a midwife—to join the register. Those standards must comply with European legislation; we have to work to directives that cover both nursing and midwifery. We are also responsible for setting standards for some of the specialist practitioner level, which is post registration.

**The Convener:** My question is how you go about setting those standards. On what basis do you decide what the standard will be?

**Christina McKenzie:** That is done through consultation. The standards have not been reviewed since 2000, when they were reviewed by the previous body, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

The process is that the council would consult professionals, users of the health services and stakeholders in the four countries about what is happening with the work force, ask whether the standards are appropriate and determine whether practice is changing. For example, the council would consider whether nurses are taking on responsibilities that perhaps historically would have been a medical responsibility, such as prescribing, and whether we need to review the standards. There is a process for doing that. There is then a debate at council, which consists of registered members and lay members. Decisions are made about the appropriate standards that

should be set. Those standards are issued as guidance for education programmes to the various health departments and to the higher education institutions.

**The Convener:** Does the NMC look at international comparators when it sets standards?

**Christina McKenzie:** Yes.

**The Convener:** What countries do you consider? How widely would you look for such information?

**Christina McKenzie:** We would obviously look at the European standards and requirements. Outwith that, we look fairly regularly at what is happening in the wider world, for example in America, Australia, New Zealand and other countries where nursing and midwifery has a long history and is regulated—not all countries have regulation of or standards for those professions.

**The Convener:** When the NMC sets standards, does it take into account the knock-on effect that changes in standards might have on how the professions operate? A number of committee members are concerned that some of the standards that are being set across a variety of professions mean that in rural areas it is becoming harder and harder to justify continuing with certain levels of health service provision. Does any of that form part of the NMC's calculations when it sets standards?

**Christina McKenzie:** The council members would certainly take that into consideration as part of their discussions and deliberations. Their ultimate role is to protect the public; that is why the Nursing and Midwifery Council is there. The overriding factor would be what best protects the public.

15:45

**The Convener:** Does anybody else on the panel want to come in on those matters?

**Professor Rae:** One of the issues is that standards often take quite a while to respond, but something has to be done fairly quickly at the coalface. After the consultation, it takes quite a long time before you get the standards that allow you to be more comfortable with how people are working. However, there is a provision that any practitioner can take on whatever responsibility they believe is appropriate, if they are content that they are sufficiently well trained. The previous standards came out in 2000; I do not know when the next lot are due. We therefore have to move along, using the original standards from 2000 as a base, and expand what is done in an appropriate way until the next lot of standards come out.

**Shona Robison:** I will focus on recruitment problems in rural areas. Does Christina McKenzie recognise that there is a difference in the skill set that may be required for a nurse who is working in a large teaching hospital in a large conurbation, compared with that required for a nurse working in a remote and rural area? Does the NMC's standard-setting take account of those differences?

**Christina McKenzie:** The standards that are set for nurses are minimum standards. For example, there are minimum standards for a nurse to be able to nurse adults. If a nurse requires additional skills and competencies because of the environment in which they work, that is covered by scope of practice documents, which are guidance documents that the Nursing and Midwifery Council produces. As Jack Rae said, nurses can have further training and development. As long as nurses feel that they have had sufficient training and are competent to undertake different roles and specialist tasks, there is nothing to prevent that.

**Shona Robison:** Is there a specific training package for nurses who want to work in remote and rural areas? Is back-up provided to encourage nurses to work in such areas?

**Christina McKenzie:** The Nursing and Midwifery Council does not develop such packages; local service providers would negotiate with higher education institutions to develop suitable packages for local need. We do not get involved in those negotiations.

**Professor Rae:** When a nurse or midwife qualifies, they have reached the benchmark that is set for the United Kingdom. We do not know at the beginning of the training, or even at the end, where the nurse will be employed—it could be in an acute ward, a surgical area, a highly intensive care ward, or in the community in a remote and rural area. A great many institutions work closely with services in remote and rural areas to develop programmes to meet requirements.

The situation may change. For example, it appears that there will be fewer general practitioners in remote and rural areas, which means that development beyond the initial qualification will need to be supported because there will be more nurse, midwife and other professional-led services. Those workers must have a link to central support and, for example, know when to go to a general practitioner. When people qualify, the type of work that they do will determine what additional qualification, training or support is needed.

**Shona Robison:** What work is being done on the advanced roles that nurses may take on in remote areas?

**Professor Rae:** A variety of initiatives arose from the remote and rural areas resource initiative, which no longer exists but which is being continued by NES. Up and down Scotland, from Inverness and the far north to Argyll, a variety of initiatives exist, each of which addresses a part of the whole, but they do not consider the whole picture in a coherent way.

**Shona Robison:** Does not the whole picture need to be considered? We need a national strategy to address the issue, but there is not one.

**Professor Rae:** As far as I am aware, there is no strategy to consider the additional preparation that people who intend to work in remote and rural areas will need.

**Shona Robison:** That is a clear gap.

**James Kennedy:** I want to give an example of good practice, which we sometimes need to consider. Professor Rae is being a bit modest. A little while ago, I spent a few days in the hospital in Campbeltown and met nurses who are developing through distance-learning work that the University of Paisley has developed. There are good examples, but Professor Rae is right that the work must be joined up and more effective.

**Bridget Hunter:** The lack of GPs in rural areas means that there are initiatives, particularly in community nursing. One of them is the family health nurse initiative, which the committee may have heard about. That initiative considers innovative ways of bringing in, integrating and using skills that are pertinent to nursing rather than medicine. The scheme provides a broader range of skills—such as those that district nurses or district midwives have—that are more about coping within the rural setting. The initiative is being considered as a model for urban areas such as Glasgow to find out whether it can be adapted to make it suitable for those areas.

**Mr McNeil:** The witnesses mentioned the knock-on effects of co-ordination, or the lack of it. In today's evidence session, and in the previous one, most people who have given evidence have said that work force planning is not their responsibility.

**The Convener:** That is a fair comment.

**Mr McNeil:** We have heard that from the RCN, the midwives, the medical schools and Paisley University and so on, but we have also had the warm words—which we get at a local level as well—that "This is all a teamwork game" and "We are all interrelated" and so on. Where is the evidence that medical schools are working with universities and that the colleges are working with one another? I can understand the perspective. You are serving a specific group of people who have a particular aspiration in their career, but where is the evidence that work is being co-ordinated? If it is not, what needs to happen? I presume that all health professionals are in these boxes. When do they get the opportunity to be educated and trained together, so that when they go into the health service they are more able to work with one another and afford respect and dignity to one another? Patients would benefit from that.

**Professor Rae:** I go back to my earlier point that there needs to be an examination of what the patients or clients—whatever you want to call them—need and what is the best work force to meet that. We then need to begin to prepare that work force. There are 136,000 people in the health service in Scotland, and they tend to be pigeonholed into particular areas of operation. A lot of work is being done. I am aware that most of the medical schools—and the postgraduate medicine courses—work closely with their local client group. However, that is mainly medicine. The schools of health, nursing and midwifery, and the allied health professionals, work closely within their own groups, but there is no clear overarching bringing together of all of that.

We could spend all day talking about the idea of training together. There are different backgrounds involved, but there are some elements of combined training. The seven training schools for nursing, the four other colleges that offer nursing but which are not part of the contract system, and the five medical schools do not merge together. However, we can consider not only to what extent we can get folk to be taught together, but how, once they are qualified, we can get newly qualified staff to work together and, in that way, begin to get to know and to respect one another. That might be one way of doing it.

**James Kennedy:** Mr McNeil paints quite a depressing picture, which is no doubt why he is considering that issue. My experience, from visiting a number of clinical environments throughout Scotland, is that, while the professions may well train separately to some extent, they have a shared focus on patients and on delivering high-quality patient care. That is the area in which we would want to consider the issues. On your question about solutions at a strategic level, that must involve considering the nature of the service at a national level, what the nature of the work force is, and then how we will supply that.

**Mr McNeil:** One example in our evidence gathering described nurses who were dealing with pain management for terminally ill patients working their way around a reluctant GP. That is not good working.

**James Kennedy:** I completely agree.

**Mr McNeil:** We are talking about capable nurses, providing a dedicated service to terminally

ill people, having to take into account the sensitivities of a general practitioner who may be offended and may stop that practice. That is only one example—I am sure that there are others, but I do not want to be negative. I know that there are also great examples—I had better watch what I am saying because there are two nurses in my family.

**The Convener:** I sense demarcation disputes here.

**Bridget Hunter:** That is exactly what this boils down to. All the professions in the NHS have territories of which they are very protective. They have to be—it is historic. I do not know how we will change that, other than perhaps, as I said earlier, thinking about a multistrata work force. There is some core training together—there has to be—but such a work force would involve the professions that are allied to medicine working across professions. Each would get a chance to see what the others do, so that they are not so protective about their issues, and so that they can understand other professions. That does not just apply to health. One of the starkest reminders of that is what happens between the health professionals and social work. The joint future agenda is trying to overcome that, and to make things better for the patients that we serve. However, such demarcation lines exist even within the health service.

Duncan McNeil is absolutely right that the best way to overcome those problems is to bring people together at foundation level. That will allow people to see where they do the same thing and where they share similar aims and objectives. We need to find ways of seeing what is common to what we do and how we can prevent duplication and waste of money. Hopefully, that will help to get rid of territorial attitudes.

**The Convener:** Finally, the committee has received petitions about the withdrawal of consultant-led maternity services, which has become a controversial issue throughout Scotland. What measurable effects has the withdrawal of such services had? Does the panel have information on that that could be given to the committee?

**James Kennedy:** I will take the issue away and make a written submission to the committee.

**Christina McKenzie:** I, too, will come back to the committee on that.

**Professor Rae:** There is evidence that midwives are taking on, and are prepared to take on, considerably more responsibility, but there is a tremendous public aversion to change. In some areas I know that the local press has signalled that this is the end, as if the lives of pregnant women would no longer be safe when they are looked after by a midwife rather than by a doctor. A big presentation is needed to change that. Midwifery and nursing-led systems should ensure that people are as safe as they are now.

**Christina McKenzie:** I support that. There is a misconception that midwifery-led care is a downgrading of service. However, evidence from various units across the UK suggests that midwifery-led services can provide better outcomes. There is an issue about the management of the information.

**The Convener:** Any further written information that the panel can provide on that will be very useful. I thank the panel for coming along—

**Carolyn Leckie (Central Scotland) (SSP):** I have been sitting here for an hour.

**The Convener:** I am sorry, but the panel has already had to sit for 15 minutes longer than was advised, so I will close the meeting.

**Carolyn Leckie:** I did notify you.

**The Convener:** I must close the meeting. I thank the panel members for coming along. We look forward to receiving the information that they indicated that they would provide.

*Meeting closed at 15:59.*

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice at the Document Supply Centre.

No proofs of the *Official Report* can be supplied. Members who want to suggest corrections for the archive edition should mark them clearly in the daily edition, and send it to the Official Report, Scottish Parliament, Edinburgh EH99 1SP. Suggested corrections in any other form cannot be accepted.

The deadline for corrections to this edition is:

**Thursday 14 October 2004**

Members who want reprints of their speeches (within one month of the date of publication) may obtain request forms and further details from the Astron Print Room, the Document Supply Centre or the Official Report.

PRICES AND SUBSCRIPTION RATES

OFFICIAL REPORT daily editions

*Single copies: £5.00*
*Meetings of the Parliament and annual subscriptions: £350.00*

The archive edition of the *Official Report* of meetings of the Parliament, written answers and public meetings of committes will be published on CD-ROM.

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

*Single copies: £3.75*
*Annual subscriptions: £150.00*

Standing orders will be accepted at the Astron Print Room.

Published in Edinburgh by Astron and available from:

**Blackwell's Bookshop**
**53 South Bridge**
**Edinburgh EH1 1YS**
**0131 622 8222**

**Blackwell's Bookshops:**
243-244 High Holborn
London WC1 7DZ
Tel 020 7831 9501

All trade orders for Scottish Parliament documents should be placed through Blackwell's Edinburgh

**Blackwell's Scottish Parliament Documentation Helpline may be able to assist with additional information on publications of or about the Scottish Parliament, their availability and cost:**

**Telephone orders and inquiries**
**0131 622 8283 or**
**0131 622 8258**

**Fax orders**
**0131 557 8149**

**E-mail orders**
**business.edinburgh@blackwell.co.uk**

**Subscriptions & Standing Orders**
**business.edinburgh@blackwell.co.uk**

**RNID Typetalk calls welcome on**
**18001 0131 348 5412**
**Textphone 0845 270 0152**

sp.info@scottish.parliament.uk

All documents are available on the Scottish Parliament website at:

www.scottish.parliament.uk

**Accredited Agents**
(see Yellow Pages)

and through good booksellers

Printed in Scotland by Astron