HEALTH COMMITTEE

Tuesday 9 November 2004

Session 2

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HEALTH COMMITTEE
25th 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 GAVE EVIDENCE:

Mark Butler (Scottish Executive Health Department)
Mr Andy Kerr (Minister for Health and Community Care)
Dr Annie Ingram (North of Scotland Planning Group)
Patricia Leiser (West of Scotland Workforce Development Group)
James McCaffery (South-east and Tayside Region Planning Group)
Mike Palmer (Scottish Executive Health Department)
Dr Mairi Scott (Royal College of General Practitioners Scotland)
Professor Graham Teasdale (Royal College of Physicians and Surgeons of Glasgow)
Professor Tony Wildsmith (Royal College of Anaesthetists)

CLERK TO THE COMMITTEE

Simon Watkins

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

Roz Wheeler

LOCATION

Committee Room 1

Scottish Parliament

Health Committee

Tuesday 9 November 2004

[THE CONVENER *opened the meeting at 14:03*]

Item in Private

The Convener (Roseanna Cunningham): Good afternoon. As everybody is settled, I welcome back to the Health Committee the three witnesses—Professor Tony Wildsmith, Dr Mairi Scott and Professor Graham Teasdale—to give further evidence. We will stick to 30 minutes per panel of witnesses today. Mike Rumbles will begin the questions to the witnesses.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): Do we not do item 1 on the agenda first?

The Convener: Yes, you are right. I have missed a brief item.

Does the committee agree to take in private item 3, on the work force planning inquiry, to give us an opportunity for preliminary consideration of what the general themes of our draft report will be?

Mike Rumbles: I have a general point to make. I genuinely feel that we should try to take as much of our business as we can in public. I appreciate that when we are considering a draft report, we are on a different plane, in that the draft could be misconstrued by people outside the committee and so there is an argument for discussing draft reports in private. However, all that you are asking us to do is to consider what our main themes are likely to be, and, as they are perfectly obvious to anybody who has been watching our evidence-taking sessions, it does not serve much purpose to go into private.

The Convener: Are you moving that item 3 not be held in private?

Mike Rumbles: I would rather that we held it in public. That is the default position of the standing orders and therefore of the Parliament.

The Convener: There is a proposal that item 3 be held in public, not in private. Is anybody opposed to what Mike Rumbles suggests?

Members: No.

The Convener: It looks like you have won this one, Mike.

Mike Rumbles: Thank you, convener.

The Convener: That means that item 3 will be held in public and not in private.

Work Force Planning Inquiry

14:07

The Convener: I welcome our three witnesses again. It is back to Mike Rumbles.

Mike Rumbles: I thank the witnesses for coming back for a second evidence-taking session, which is, I think, unprecedented.

My first question gets to the nub of the issue: the perception that medical services in Scotland are being centralised and the problems that we have in our rural hospitals. We are often told that the drift to centralisation is because of safety and because the specialists who are involved in surgery have more operations to do if we centralise. The royal colleges set the standards, and we are told that, because of the very high standards that are required, we need to centralise—in effect, because of the better success rates in bigger services. Our rural hospitals and the surgeons who do surgery in them suffer because they do not have the throughput of patients and their success rates are lower. I even heard the Minister for Health and Community Care on radio this morning likening the situation to flying an aeroplane. He said that the passengers would want to know that the pilot of the plane was well used to flying the aircraft and did not fly it only once a year.

Where is the evidence of success rates in urban hospitals that serve populations of 450,000 and above? Are we talking about a success rate of around 97 per cent as opposed to 60 per cent in rural areas or about 97 per cent and 95 per cent? We must be in a position to make a judgment about what the experts, such as you, tell us about success rates and services.

Professor Graham Teasdale (Royal College of Physicians and Surgeons of Glasgow): Your questions raise many points. There is overwhelming evidence of a relationship between specialisation, volume of patients treated, size of hospital services and improved outcome. There have been reviews. One in an American journal two years ago reviewed 135 papers, 70 per cent of which came out in favour of volume giving better results, so there can be no doubt about the existence of the fundamental relationship.

However, matters become more interesting when we investigate the strength of the relationship for particular conditions and how much expertise and experience a surgeon has. There is a range of evidence. I realise that I am generalising but, to some extent, the more complicated the condition, the more likely it is that, because of specialisation and volume, large hospitals will get a better outcome. Indeed, the

fact that straightforward heart attack cases have better outcomes in more specialised, larger units makes that relationship clear.

That simple answer highlights the fundamental point. However, your question about the percentage success rate for treating a particular condition in a particular place is much more detailed and has no simple general answer. The matter needs to be carefully examined from condition to condition and from place to place.

Mike Rumbles: I appreciate that answer, but it sets out a generalisation that we all accept. We are trying to tease out from you as professionals the percentage success rates and to get at the value judgment that is being made. After all, logic dictates that the more patients a doctor sees, the better he or she becomes at treating them. We need the evidence. We need to see the success and failure rates for each hospital to ensure that members of the general public and people like us who are responsible for them can make that value judgment. I accept your general point that logic dictates the matter but, at the end of the day, where is the meat? I need to know whether we are talking about a small and relatively insignificant difference or about a major difference.

Professor Teasdale: There is no simple answer to that question. I point out also that the drivers for change in the delivery of services are not simply matters of specialisation. We must also bear in mind issues such as the work force and the ability to deliver services across the number of sites in Scotland. The two go hand in hand. Hospitals that need to concentrate services to maintain cover are likely to benefit from specialisation.

Mike Rumbles: But the evidence that we have received suggests that specialisation is the major driver; indeed, it is the nub of the issue. I do not wish to be difficult, but I feel that you are giving me a generalised answer when I am after specifics. I wonder whether any of the other witnesses can help out here.

Professor Tony Wildsmith (Royal College of Anaesthetists): Perhaps I can comment; after all, anaesthetists spend a lot of time watching surgeons in a number of ways. I have no doubt that, for all procedures, specialisation makes for a better end result. Indeed, there are data to back that up.

You should really ask about the operations that need to be carried out in more remote and rural areas and whether there is a critical mass of patients to allow surgeons and anaesthetists to deliver occasional services in a pro-active way. The more difficult question is how we provide an emergency service when a force 8 gale is blowing and we cannot transfer a patient. From our perspective, we do not know which cases we need to provide a service for. As I said in my original evidence, we need a needs analysis. I still feel the same way.

Mike Rumbles: Can I come back on this issue one more time, convener?

The Convener: Yes, just once more.

Mike Rumbles: I just feel that, when we come to produce our report, committee members will be asked to make certain decisions. This is a fundamental issue. I grant that there are other factors such as the location of services in rural and urban Scotland. However, my question cuts to the heart of the issue. I accept the logic behind what the professionals are telling us, but they must be able to give me a broad indication off the top of their heads of whether we are talking about major differences. After all, they said that the evidence existed. Are we talking about a success rate of 90 per cent in urban areas and 60 per cent in rural areas? I will not hang anyone out to dry if they are wrong about the margins, but they have to give us a steer. Are we saying that the success rate in each area is 90 per cent and 60 per cent or 97 per cent and 95 per cent? Is the difference less than that? We need to know.

Professor Teasdale: We are talking about a range of values across different clinical circumstances. For example, in my specialty, mortality was halved by concentrating services. The brain is a complex area and the success rates for conditions that affect it might differ in each area by 10 or 20 per cent. For other conditions, the difference might be small. However, even if the trend is not very strong, it will always be apparent.

Mike Rumbles: Where can we get the statistics for those operations? Can you provide us with them?

Professor Teasdale: There is no body of evidence that is sufficient to answer every question on every condition in every clinical circumstance. One should perhaps be guided by the application of the fundamental principle and the recognition that it will apply to varying extents in varying circumstances. I know that that is less than what is desired, but sometimes absolute evidence is just not available. The fact that evidence is not absolute and factual does not mean that it is not there. The converse is that I am not aware of any evidence that suggests that treatment in a smaller unit by a less specialised, less expert person gives better results.

14:15

Professor Wildsmith: I know that Mike Rumbles regards the issue as being important, but it is not the only important issue. Once what needs to be provided has been identified, we can explain

how to provide staff that can deliver the service safely. However, we need to know what we are being asked to do and what can be transferred, because many surgical procedures, those in Professor Teasdale's speciality for instance are provided in only four sites in Scotland, because they are extremely specialised. We can provide people who get the training and experience to do what is needed, but they can do that only if their hours of work let them do it and only if enough people can be recruited to provide the service. I think that those are much more important issues.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): I think that we all agree that we are considering a number of issues. Simple folk that we are, it is easy for us to understand the impact of a new deal for junior doctors or of the limiting of hours that the European working time directive has caused, but specialisation and sub-specialisation are a multiplying factor. Together, those factors are driving the centralisation process.

Simple folk that we are, we are being told that centralisation is for our own good. Its purpose is to improve quality and quality outcomes. I am confident that there is a consensus that, when it comes to life-threatening conditions—whether that is heart disease, the need for a heart bypass or cancer—people are quite happy to go to Glasgow to take the best chance that they can get. My community has accepted that for many years and there is no dispute about that. However, a dispute does arise when that logic is applied to every other procedure without any scientific basis.

How many specialisations and sub-specialisations are there? Do they all add value? I accept the simple analogy that we have heard about this morning—of course we do not want to be flown by a pilot who is on their first flight—but what is the difference between someone who does 500 of a particular operation in a year and someone who does 750 of them? What does the experience of doing those extra operations add? Is there not some evidence that there is an optimum size of hospital that produces outcomes that are equivalent to those that big hospitals produce? Have such findings not been published recently in the *British Medical Journal*?

The Convener: The witnesses have all gone quiet.

Professor Teasdale: Again, that was a highly relevant question, but I come back to what Professor Wildsmith was saying. There is a need to examine what is required and how to provide that. The first thing that is required is access to services, which I do not think that anyone is talking about withdrawing. The idea that moving services around removes access is wrong.

It is easy to see the colleges as the bad guys, but the colleges are not the decision-making organisations. We provide advice; that is all. We interpret the advice that we receive from the specialists in the various areas. In surgery, there are nine major specialties. I do not think that anyone would say that a person should operate on a patient's hip one day and on their stomach the next day, because those are two separate specialties. However, there is emerging evidence that it is better for a patient to have their stomach operated on by a specialist in one area if the problem is at the top of their stomach and by a specialist in another area if the problem is at the bottom of their stomach.

Techniques and expertise in medical science advance all the time and, through that process of gradual improvement, patient outcomes have improved dramatically over the time that I have been in practice.

We need a debate about how services are provided across Scotland. The desire to have debates in individual places is fully understandable but will not give the bigger picture. There is a challenge across Scotland—especially in acute services.

I make no apology for mentioning again the double whammy that makes this issue so pressing—the working time directive and the SIMAP and Jaeger judgments. The effects of those were not foreseen two years ago. The effects are especially hard on Scotland because of the greater number of hospitals here. In England and Wales, they have roughly half the number of hospitals per head of population that we have—we have just under twice as many as they do. In most large English and Welsh hospitals, there would have been five registrars and five senior house officers on call at night. Each would have been on a one-in-five rota, which was perfectly acceptable. In Scottish hospitals, five people would have been in one hospital and the other five people in another hospital. As of August, because of the working time directive, we had to have a one-in-10 rota. English and Welsh hospitals could achieve that by fusing the two layers into one. Instead of having two lots of five they had one lot of 10, and the hospitals were covered 24 hours a day, seven days a week, every week of the year. In Scotland, we had 10 people on two different sites. Overnight, the sustainability of acute services on both sites became very threatened.

Obviously, I have been thinking about this issue a lot, just as committee members have. In searching for the particular key factor to be fixed, we have to recognise that—underneath it all, or behind the smoked glass—lies the fundamental structural problem that we have in Scotland.

Mr McNeil: You would agree that the increase in specialisations, or sub-specialisations, over the years has often meant a reduction in the number of people who have particular specialties, and has thus increased the opportunities for those people to be out of the theatre more. They go on the circuit tour.

Last time around, you focused greatly on the hours of junior doctors and on the European working time directive, but specialisation and sub-specialisation are having an equal impact. We have not looked into that to see whether the impact can be shaped to suit Scotland's needs and geography. In the south, the existence of major conurbations makes it easier to do that. We cannot necessarily take the model used down south and use it here. If we did, we would get the kind of results that we are experiencing now.

Dr Mairi Scott (Royal College of General Practitioners Scotland): Clearly, we are concentrating on acute services and specialisations. However, as Tony Wildsmith said, once we are clear about the logistics of planning those services and specialisations for Scotland, the role of the generalist must also be considered. We have to be more systematic in the planning of care—of patients' journeys, if you like. The generalist—the general practitioner—can do much of that work and support many of those patients if the resources are available.

If we must accept that that is the way that things are going—and that is what we are hearing—work must be done now to ensure that patients' care is not compromised. It can be done.

Mr McNeil: But the quality of care will not necessarily improve. We are being told on the ground that this is for our own good and that we will get a better-quality outcome, and in certain areas I concede totally that that will happen, but in other areas I would not concede that. From what you have said, it seems that not a lot of evidence exists on the other, bog-standard procedures to suggest that quality will improve.

Professor Teasdale: Just last week, my college received data from the Veterans Health Administration in America on hernia surgery, which is a fairly straightforward and common procedure. They suggest that improvement continues even after people have done 250 operations of that type, which illustrates that there can be a long learning curve even for simple procedures.

I accept your point that the benefits of specialisation can vary, but they do exist. Just a few years ago, we were criticised because surgeons did too many procedures that were outwith their competence and patients suffered when they were treated by people who did not have the expertise or experience. That situation was wrong. We need to get the right balance, which might be different in different places. That is accepted.

At a two-day meeting two weeks ago, the Association of Surgeons of Great Britain and Ireland debated the appropriate balance between generalist training and specialist training. In its conclusions, the association stated that it

"welcomes increasing specialisation … accepts that increasing specialisation will produce varying pressures in different hospitals and that one model for emergency provision will not be appropriate … Hospitals serving small populations … are vulnerable and have particular needs."

The profession has to balance the competing requirements of improving outcomes and meeting people's general aspirations for services that can be delivered conveniently.

The Convener: Before I let Shona Robison ask her question, I want to ask whether that debate is perhaps about defensive medicine. Is such a thing developing because of a fear of litigation?

Professor Wildsmith: That is relevant to the specialisation issue. If people become specialist, they become more efficient and effective and patient outcomes improve in a number of ways. However, it will not be possible to have specialists in every aspect of surgery out on Lewis. Therefore, we need to identify what specialist activity and capability is needed in those kinds of settings. The Royal College of Surgeons of Edinburgh has put in place a training scheme for remote and rural surgeons, but I think that only one person has joined the scheme so far. The royal colleges know how to train people as long as they know what job they are training people for. They know how to monitor standards to ensure that surgeons deliver a safe standard of care. I do not think that the royal colleges have led the debate on super-specialisation that committee members have presented to us.

Shona Robison (Dundee East) (SNP): What has just been said about the role of the royal colleges is interesting. We were told earlier that their role is to provide advice rather than to make decisions, but in some ways the royal colleges are decision makers. It is difficult for politicians and the Government to say that the royal colleges are wrong and go in a different direction. As the professional bodies, the royal colleges are held in a great deal of esteem, so what they say is important.

What we have been told again today is that bigger hospitals provide better services because surgeons can perform more procedures. Where does that leave general surgery and the role of the general surgeon or physician? If we were to accept the message that has come across

consistently from this afternoon's evidence, we would have no general surgery, because, it is argued, it is unsafe. We have heard that smaller hospitals have different needs, but how does that square with the rest of the evidence that has been given today, which has suggested that clinical safety requires that surgeons perform X number of operations? Where does that leave the safety of patients who receive services in smaller hospitals?

In some ways, the evidence that we have heard has been slightly conflicting. I am interested in knowing more of the detail about the job that surgeons should be trained for. Where does the balance lie in delivering safe services to people in more remote and rural areas? Where is the evidence that the accident and emergency services that are delivered in big conurbations are safer than those that are delivered at rural general hospitals? Where are the data? I have not seen any, and it would be useful for the committee if we could have some.

Dr Scott spoke about the role of GPs and about the enhancement of their clinical skills. Will she give some examples of what she would view as being the appropriate development of GPs' clinical skills to enable them to provide some of the services that have traditionally been provided in hospitals? I know that there were a lot of questions there—I apologise.

14:30

Dr Scott: It would depend on the locality of the GP and of the available services. One example would be to ensure that a practitioner in a more remote location has the necessary resuscitation skills—although many of them already have them. Rural practitioners would work at a different level from me, as a GP in an inner-city location, where help is at hand quickly.

We could develop chronic disease management that does not require the patient to travel, using telelinks to provide local hospital support, advice and feedback. Such facilities are in place in various areas and include accident and emergency or casualty-type set-ups, some of which are nurse run. There are ways to develop those facilities quite easily for conditions other than those requiring surgical interventions—which are clearly a different matter—with GPs who have interests in different areas in addition to the skills that they need to provide generalist care and who could develop skills in those areas to address the demands that come with service redesign.

Shona Robison: Can you envisage GPs working in a hospital setting to deliver some of those services?

Dr Scott: There are good examples of GPs working in hospital settings currently. I can think of a very good example of a GP working in an accident and emergency department, not necessarily providing accident and emergency trauma services, but providing generalist services. There are various examples of that around Scotland and, as far as I can tell, those arrangements work well. However, we still have a recruitment and retention problem and expanding those services would take GPs away from general practice. That might block such developments. Nonetheless, what you suggest can be done.

Professor Teasdale: The convener mentioned litigation, but I do not think that that is a major factor, as the national health service takes out indemnity for most things.

The Royal College of Physicians and Surgeons of Glasgow has a particular role in training and in commenting on training programmes and the circumstances of trainees. That is the context in which we look at hospitals, establishing whether they are an appropriate environment in which someone can become trained in medicine, surgery or whatever. That is our clearest role. Our role also involves being asked to give advice on particular services in particular areas, for which we use our specialty groupings.

On training, we are working with the need to balance a degree of generalism with the development of specialist skills, taking into account the costs and benefits of doing so. At present, few posts are advertised by employers as being for a general surgeon. Virtually all posts are for a general surgeon with a specialist interest in, for example, the gall bladder or the colon. The balance that we are looking for in training is to have people who have developed specialist skills but who have also retained sufficient generalist ability to deal with acute circumstances.

In modern surgical practice, little surgery needs to be done during the night. Most surgery can be done the following day—that has been shown to be safer. The kind of emergency cover that surgeons need at night rarely requires complex surgery. We can see how a range of people can be involved: some of them will be very specialised; some of them will be quite specialised while keeping their general abilities; and others will provide a broader general range of activity. The relationship of those roles to particular posts needs to be flexible.

The training standards for the United Kingdom are set by the Specialist Training Authority of the Medical Royal Colleges—and now, we assume, by the Postgraduate Medical Education and Training Board. If a particular circumstance arises that would be outside the norm in larger hospitals—I am talking about smaller hospitals where there are fewer staff—it is entirely appropriate that colleges are flexible in considering the training that is

relevant to the person in post, before or after their appointment. It might be as useful—if not more useful—to generalise and extend a person's skills across the range after their appointment as it would be to try to haul everyone down to a level of general training, because it takes longer to train a generalist than a specialist; it takes longer to acquire adequate expertise across a broad area in emergency work, which is difficult and dangerous, than it takes to acquire specialist skills.

Shona Robison: Is there comparative data on accident and emergency departments?

Professor Teasdale: I do not know. I am not an expert in that topic.

Mr McNeil: On that—

The Convener: I want to bring in members who have not yet asked a question, because we are struggling with time.

Mr David Davidson (North East Scotland) (Con): Professor Teasdale said that the royal colleges have only an advisory role. However, the colleges have more influence than anyone else does. We do not dispute the colleges' role in setting standards. We are told that, over the next few years, Scotland will be between 500 and 1,000 medics short—across every specialty, including general practice. However, trainees will start to come on stream and become available to join the work force.

Given that rural areas seem to be at a particular disadvantage in relation to access to the various care models, and in the light of Dr Scott's comments about the role of generalists and the development of intermediate care, how do the colleges think that training should be organised to produce the outcome that we need? You have more influence on ministers than anyone else does, because ministers cannot argue with the training standards that you set.

Professor Teasdale: I am flattered by your comments. We have a role in giving independent advice, which must be seen to be independent and must protect patient standards. We face a difficult future, because compromises might have to be made. We might have to compromise between less specialisation—and perhaps reduced quality—and local provision. Getting those compromises right is a matter not just for the colleges, but for the whole nation of Scotland.

Mr Davidson: You refer to your advisory role. What advice would you give to the minister if he wanted to put in place a five to 10-year programme of work force planning for medical skills and asked you about the areas in which efforts should be made to train people, what the acceptable compromises might be and whether such compromises would result in deaths?

Professor Teasdale: Scotland needs to consider a number of measures. I had a little list, the first item on which was "recognise the problem". There is no doubt that the problem has been recognised. There needs to be investment in training and in the time that people have to train others over a shorter period. There needs to be investment in making it possible for more people to work flexibly—that is not currently well catered for. There need to be efforts to substitute other workers for medical workers, which can be perfectly possible. Concentration is an inevitable consequence. It will not be sufficient to consider the supply side of the medical work force; we must also consider demand. That might be unpalatable, but it is a reality that the Parliament must lead people to understand—I am not being impertinent in saying that.

Dr Scott: Training for general practice is quite different. We seek to increase training time—the new training structure that is recommended in modernising medical careers and by the PMETB will increase general practice training by a year. The situation is different for the other specialties, which seek to reduce training time. It will be important to achieve the increased training time for GPs. We also want the training programme to include more time in general practice than is currently the case—I mentioned that when I gave evidence to the committee on 26 October.

That relates to recruitment, because one problem for general practice in Scotland is that, when people finish training, they do not feel sufficiently confident about their managerial skills—rather than their clinical skills, interestingly—to take up substantive posts. Consequently, they become locums or sessional GPs and we lose them. If people feel confident at the end of training to enter substantive posts, we will retain them in Scotland. I would tell the minister that general practice training is one place to put his money.

Professor Wildsmith: We need to know what people need to be trained to do. From my specialty's perspective—the specialty has several aspects—we need to know what needs to be delivered locally and what can be transferred. There is no tidy dividing line between operations that are entirely safe to do locally and those that should be delivered centrally, but a line exists somewhere. There are hard data at one end but none at the other. If people are trained properly for the role and if their terms and conditions—which I as a college representative should not talk about—are right, they will be recruited and retained. Recruitment and retention are bigger issues than specialisation for the matters that the committee is addressing.

The Convener: I thank the witnesses for appearing for a second time. I am sure that we could continue to ask questions for much longer and we may still wish to take up issues with you, but we will do that in writing rather than asking you to appear for a third time.

I thank the next panel of witnesses for attending. We will go straight into questions rather than having opening statements.

Shona Robison: What is the level of co-operation among your groups when developing regional plans? I noticed an interesting line in the submission from the north of Scotland planning group, which is Dr Ingram's group. The document refers to the

"statutory duty for NHS Boards to work together",

after which it says:

"This is proving challenging."

How challenging? What are the challenges? What barriers remain?

Dr Annie Ingram (North of Scotland Planning Group): I said that the duty was challenging because traditionally NHS boards have had a responsibility to provide health care for their own populations, but they have not been required to work beyond board boundaries, although many have always done that. The move towards a regional way of working is difficult because it brings together groups of people who may have different interests to produce a coherent result. On learning to work together and delivering on a regional strategy, it has been interesting in the past year or so to begin to develop areas of commonality on which boards can work together. The north has many areas of commonality, which have been identified as the matters on which we would like to concentrate.

Shona Robison: One issue that has been raised time and again is the difficulty that the European working time directive and all the other pressures create for providing rotas. Is it the case now, or will it be the case in the near future, that rotas for services delivered through the night or in some specialisms can be managed for hospitals across the boundaries of the health boards that the consultants happen to belong to?

14:45

Dr Ingram: There are examples of that happening. A rota has been established to cover ear, nose and throat services in Fife and Tayside, which are part of the south-east and Tayside region planning group area. Because of smaller populations, the two health boards in those areas would not necessarily have been able to recruit the necessary staff, so they have set up a rota between them.

In some circumstances, setting up rotas across boundaries is easy; it can be a way of dealing with the problems of distance and it allows for links to be made. Health boards are thinking about ways in which to cover wider areas, particularly out of hours, because of the challenges of numbers of doctors and rotas. I do not think that cross-boundary rotas are the solution for every situation, but they would be a solution for some specialty areas.

Shona Robison: You mention specialty areas, but could cross-boundary rotas work for more routine services? For example, might they be a solution for those who are trying to maintain accident and emergency services over a number of sites where specialist back-up is needed to ensure that the services can be delivered? Do you foresee rotas operating on that basis, particularly through the night, to back up front-line service delivery, such as accident and emergency?

Dr Ingram: I do not know whether it is necessarily right to describe the model that you are talking about as "rotas", but it is a model for the future and is already being used. An example is the provision of out-of-hours emergency services in the Thurso minor injuries unit. The unit does not need full accident and emergency services, but it needs back-up and, through telemedicine links, the unit's staff have linked to the accident and emergency staff—whether specialist registrars or consultants—in Aberdeen royal infirmary to have access to additional support to deal with patients and to get advice about whether a particular patient can be maintained locally or needs to be transferred.

Mike Rumbles: We have heard a lot about numbers in the evidence that we have taken. The Executive is to recruit hundreds of new consultants, it has a target of 1,500 extra allied health professionals and it is bringing in thousands of new nurses and midwives. However, it has given no figures yet for GPs. The Calman report recommends that an additional 100 students should be recruited to medical schools in Scotland, but we have just heard in evidence from the Royal College of General Practitioners Scotland that, over the next eight or so years, we could be 500 GPs short. We will press the minister on whether he will implement the Calman report, but do you believe that the report goes far enough? Will 100 new doctors solve the problem?

Patricia Leiser (West of Scotland Workforce Development Group): The challenge is to move away from an input focus, which concentrates on numbers of doctors, nurses or other health professionals and thinks about them as doing separate jobs, to an output focus. That is challenging, as you have heard in some of the evidence that you have taken.

I think that you asked a previous panel whether work force planning was a new phenomenon, but it has taken place in Scotland for a considerable time. At local service level, it has mainly been concentrated on the services in which change is occurring, such as mental health services, whereas at national level it has taken place in relation to student nurse intake numbers, for example. The challenge is to move away from the silo thinking on work force numbers and to consider the whole work force. The roles that we have played for a time or are starting to play in the regions are about trying to emphasise the whole work force rather than thinking only about doctors or nurses. Clearly, some of those groups play a particular and significant role in service planning, so numbers are important, but so are skills and roles.

On the GP shortage, the royal college has clearly done work indicating that 500 more GPs would be helpful. I do not necessarily want to comment on that because I do not have the details, but the new contract for general medical services gives an opportunity to look much more flexibly at how those services are provided and encourages us to consider not only roles for GPs. As previous witnesses have said, looking across boundaries of staff groups is a key facet.

Mike Rumbles: The previous witnesses said that they did not think that the 100 medical students that Calman recommended would be sufficient to solve the problem, but you are saying the reverse of that and that, with the new ways of working and everything else, you do not want to focus on that matter. I want to press you for an answer to the specific question. Are you saying that, regardless of whether the Executive accepts the Calman recommendation that there should be an additional 100 medical students, that matter is not of major significance?

Patricia Leiser: I am not saying that it is not important. Significant work has obviously been undertaken to produce the Calman report, which I was not party to, and I bow to the key individuals who were involved in that work and in making that recommendation. If it is endorsed, we will obviously work with it. I am not saying that that recommendation is not as important; I am saying that it is not the only answer. The danger is that we consider inputs rather than outputs and individual staff groupings in isolation. In the past year, there has been an impetus for us to look across staff groups rather than only within staff group boundaries.

Dr Ingram: One thing that Professor Wildsmith said is true of all parts of the service. We must consider what the health need is. I have not looked at the report from the Royal College of General Practitioners, so I cannot comment on whether the numbers are right. The work that has been done with Calman begins to take us further down the road, but one problem that we had until work was instigated by Professor Kerr's group was that we had not looked at what the service need—the health need—was across the whole of Scotland and, therefore, at what we needed to deliver. If we do not have such information, we cannot be sure that the numbers that we have are the right ones.

The Convener: From where would a Scotland-wide survey of need have to emanate? Who would have to do it?

Dr Ingram: Obviously, part of it would come from public health colleagues across the areas. Currently, a lot of work is done within individual health boards on health planning and their public health reports. There is a lot of evidence around. We need to take a whole-Scotland look at that evidence in order to begin to develop an understanding of what the health needs are, although a number of those needs have already been raised by the committee.

The Convener: If a survey has not been done and it needs to be done, how should that be driven forward so that we have a survey? Who should take ownership of the work?

Dr Ingram: I think that that is part of the role of the regional planning groups. I have a different role from my colleagues, as I have responsibility for both planning and services. I think that the regional planning groups should work with the report that will come from Professor Kerr and begin to take the framework forward into another stage.

Janis Hughes (Glasgow Rutherglen) (Lab): All your submissions mention recruitment, retention and training opportunities. As you know, the Executive is committed to recruiting and retaining an additional 12,000 nurses and midwives by 2007 and 1,500 extra allied health professionals. On the current vacancy situation, I noted with interest the comments about the innovation of the health care academy in Lothian, notwithstanding some of the projects that are currently being tried. What impact do you think that that will have on the targets?

James McCaffery (South-east and Tayside Region Planning Group): The targets are very much in line with expanding the work force. The nursing work force is particularly important, because nurses pick up many of the roles that GPs, hospital consultants and doctors used to perform. Over the past five or six years in the SEAT area, we have increased our nursing complement by just under 600, so we are doing well. However, we must change some of our approach to flexible working in order to make it more opportune for people to come back. Part of

our role is to get the maximum out of the work force, whether that is nurses, consultants or GPs. That involves understanding working lives better and we are doing work on that.

To release nurses to do the work, the health care academy becomes important for clinical and clerical support workers. It is important that we provide the necessary training to support those individuals, who are getting accreditation to do many more things than they could do in the past. That will be essential if we are to be able to live with the demographic time bomb that our aging population represents. Nursing recruitment is probably critical, in that it allows us to release doctors to do some of the more essential tasks that only they can do. Nurses can then do the things that only they can do and support staff can fill in the gaps, but we must ensure that they are trained and accredited to do the work.

Janis Hughes: How are some of the initiatives that are coming on line as a result of the European working time directive and the many other changes that have already been mentioned affecting the Executive's commitments? An example of the new innovations that have been brought about is the hospital at night initiative, which involves groups of health professionals in performing different roles. How does that impact on the Executive's targets? Are those targets still realistic? Do they cover some of the new roles that health professionals will be expected to play because of legislation that is having an impact on staffing?

James McCaffery: The targets look realistic as regards what is coming out of the nursing schools. It is important that we give people challenging tasks. The hospital at night initiative, which involves nurse practitioners coming to the fore, is an example of that. For too long, we did not maximise the energies and potential of our staff. These days, we are much more focused on doing that. I think that the numbers in the targets are correct.

Mr McNeil: On page 2 of your submission, you say that there needs to be a balance between specialisation, sub-specialisation and generalist training. You then go further, by outlining in a case study the negative impact of sub-specialisation. You mention the recommendation on paediatric anaesthetists, which will have a negative impact on how we treat children. You say that an average-sized district general hospital will not be able to treat children who are under three years old. Given the debate that we had the last time—

The Convener: Mr McNeil is referring to Dr Ingram's evidence.

Mr McNeil: Sorry.

Dr Ingram: Can you repeat the question?

Mr McNeil: On a number of occasions, the submission from the north of Scotland planning group discusses the impact of specialisation and sub-specialisation. You express a desire for a balance to be struck between specialisation and generalism and then, on page 3, you go further, by pointing out in a case study the negative impact that specialisation will have for the anaesthetisation of children under three in district general hospitals. In fact, you say that that will not be possible in the future.

Dr Ingram: That is an example of something that has happened.

Given the specific challenges that the north of Scotland faces, it is especially important for us to be able to maintain services as close to patients as possible. Much of the work that we have done tells us that there is a need to consider what a generalist can do. There are examples of how that process is developing across the north of Scotland. It is right to say that, in future, it will not be possible to do some of the things that we do in some areas at the moment.

I gave an example of something that has happened—children who are under three have been moved from one hospital to be treated in another hospital, because of the numbers of children that the hospitals dealt with. The issue was to do with whether enough children were treated to allow the anaesthetists to maximise their skills. I am probably not the best person to give the reasons for that—our colleagues from the royal colleges would probably be better placed to do so. That is my understanding of the way that sub-specialisation can impact on local services. There are some things that we will be able to do and some things that we will not be able to do.

Mr McNeil: Given our recent discussion with representatives of the royal colleges about the matter being all about quality and everything else, it is useful to hear that specialisation is having an impact on the front line, just as the junior doctors' hours and the European working time directive are having an impact.

15:00

The Convener: I would like to follow up the issue that Duncan McNeil raised. On page 2 of your written evidence there is a lengthy paragraph that says, in effect, that although Scotland is a rural country, we have—for presumably historical reasons—an entirely urban-centred process of producing our health professionals. Do you agree that decisions are being made by the royal colleges and other groups of health professionals without their taking real cognisance of the impact that those decisions will have on rural areas? Do you think that they are simply not able to make

that leap of thought to how their decisions will impact in rural areas?

James McCaffery: I have just returned from Leeds, which is the largest health care organisation in England. The same process is happening there. Harrogate, which covers 147,000 people, and Huddersfield had all their paediatric anaesthetic services moved to Leeds. That was not necessarily a decision of only the royal colleges; there was a degree of self-selection by the consultants, who felt that they were not specialist enough to deal with children under three years. It is not just happening in Scotland; it affects England as well.

The Convener: I am asking specifically whether any account is being taken of the impact on rural areas of decisions that are made at professional level. Are the professionals considering that impact?

Dr Ingram: The situation is changing. Traditionally, health care education was provided in education establishments; therefore, we took students into the big conurbations to deliver not only medical education, but nursing education and AHP education. However, the UHI Millennium Institute, for example, has developed a nurse training system that is in place in the Western Isles and which is attracting local people to nurse training programmes. They stay on the islands for the majority of their training and then, for about nine months, they go to Inverness for experience. That shows how training can be delivered locally in a way that allows people to stay within their communities. In my view, that is how we might begin to address some of the issues that we face.

The royal colleges also gave evidence about the rural surgical fellowships, and a small number of people have taken up those fellowships. Although we do not require huge numbers to come out of them every year, we require them to be developed. We have been able to recruit those people to work in our island health boards.

The Convener: Would there be an advantage in intakes to university courses including protected places for people who come from rural areas because they would be most likely to go back to rural areas to practice? That is what you seem to be suggesting.

Dr Ingram: That is certainly the view of a number of the health boards with which I work closely. Another view is that we should provide as much training as possible locally; however, that cannot be done for everything.

Mr Davidson: One of the most important comments in the submission from the West of Scotland work force development group is that work force planning has not been commonplace within the NHS, although the service is now turning its mind to it. We have heard over several meetings much evidence about attraction and retention of all types of medical professional. Given what the convener just said, and given the evidence that we have heard that people go to university here but not everybody stays here, or they get to the edge of becoming a consultant then go walkabout, the issue comes down to competition—which was mentioned—and terms and conditions. A previous witness suggested that terms and conditions are a major factor in retaining people past the initial training stages. What steps are you taking, have you taken or do you plan to take to deal with those matters, especially retention? What flexibility do health boards and regional planning groups want in dealing with terms and conditions in specific areas where there are major problems with either attracting or retaining professionals of all types in the health service?

James McCaffery: We are in an international health economy and a great deal has been made of the flow of staff in and out of Scotland. During the six years when I was in Leeds, moves were roughly neutral. About six consultants moved between Edinburgh and Glasgow and Leeds and about six went the other way. We lost many more consultants to Australia than to anywhere else. It is a fact of life that we are competing in an international health economy. The new consultant contract and the general medical services contract will help us to compete. In anticipation of the question, last week I talked to some foundation hospitals in England, which say that they will stick to the national terms and conditions. Under the new contracts, we have the opportunity to introduce recruitment and retention premiums. We have decided that we will consider those on a Scottish basis, which will allow us to focus on where vacancies exist. However, it is much more important to design jobs that are attractive to individuals.

Remuneration is only one element. I returned to Scotland for the quality of life here compared with England; I can assure members that many people do that. The essential issue is to ensure that our hub-and-spoke models work well and there are, in the SEAT region, already many examples of that. We employ people in Edinburgh who also provide extensive services in Galashiels and other places in the Borders, which is important. Service and job design are as important as remuneration, so the money that is being invested in the new consultant contract and the GMS contract, with agenda for change to come, will make the UK much more attractive. We must then make jobs in Scotland more attractive than those in England.

Mr Davidson: The evidence that we have received suggests that when people refer to conditions they are talking about the working

environment and skills-development opportunities. We have discussed the skills base with the colleges. What elements of that are you examining?

James McCaffery: The consultant contract makes provision for two and a half programmed activities, which amounts to 10 hours a week. Those activities are focused on professional and educational development for consultants and others. There is also a safeguard of 10 days a year in the consultant contract; the same contract applies in England and Scotland. I have experienced both sides and see no difference between England and Scotland in that respect. A great deal has been made of the difference that is said to exist, but I do not see it.

We put a lot of time into education and training. As Dr Ingram said, we must now apply that to the whole work force because there has been too much concentration on some of the professional groupings. We need to ensure that the multidisciplinary team is better trained, which will take some pressure off the professionals.

Patricia Leiser: We know that pay is not the only issue. Jim McCaffery made a point about role development. Career ladders are now different and recruitment and retention are better in areas where people are able to develop their roles innovatively.

Another issue is the work-life balance. We know that our work force is predominantly female and that our population is aging. We have a work force that is subject to pressures from child care and the need to look after relatives, so we must take that into consideration. Across the country, there are good positive examples of greater flexibility and implementation of family-friendly policies.

We also need to consider the environment within which our staff work. It is useful to refer to the staff survey. David Davidson is right to say that it is important not only to recruit people into the service but to hang on to current staff. In all boards, staff were asked in the survey whether they enjoy working for the organisation; I cannot remember exactly how the question was phrased, but it revealed that staff's enjoyment of their work was significantly high. We must build on that and work with staff to understand why they are happy to stay, but we must also ensure that we understand why people leave. The committee asked a previous panel of witnesses about exit interviews. We need to gather that information and ensure that our strategies are focused on learning from staff.

The Convener: Shona Robison has a question about rurality.

Shona Robison: We have talked about designing jobs that are attractive to individuals. I want to apply that to rural and semi-rural contexts. Some English health authorities have fairly aggressive recruitment policies—they really sell jobs to individuals. Can we do that to recruit people, particularly in rural settings? How can we capture people before they drift off elsewhere? Is the solution in how we design jobs, in how we reassure people or in offering good research opportunities? What will it take to keep people working in the Scottish health service in rural areas?

Dr Ingram: The problem of getting the work force into rural areas is not a problem only for Scotland. I recently attended an international conference on the work force, at which remote and rural areas issues were raised by representatives from Canada, Australia, the United States and the UK. The problem of not having the necessary work force in remote and rural areas is a global one.

We must try to grow our own work force in such areas. An example of good practice is the centre for rural health research and policy, which was established by the remote and rural areas resource initiative and has undertaken a significant amount of research into what is required for the work force. The centre recently carried out work on clinical peripherality, education and training and what general practitioners, practice nurses and allied health professionals require to work in rural areas. The north of Scotland planning group has been working with NHS Education for Scotland to try to make progress on that. We are beginning to consider how to support people in their roles and in education for their roles.

A lot of work is being done to design roles for specific areas. In the example that I gave about Thurso, the nurses worked in a community hospital in an old-fashioned casualty department. When we changed their role, their skills set went up significantly through the telelinks to formal education and the education that they got from working with people in other areas.

Shona Robison: One person has now started work after doing specific training to become a generalist in a rural general hospital. Would it help if we proactively encouraged local people, perhaps through incentives, to train as generalists who can staff rural general hospitals? There are many ifs and buts, as well as the question whether we can hold on to those people, but would you go as far as to say that, from beginning to end, we need to put people into the system whom we think are more likely to go to rural areas?

Dr Ingram: I have been fortunate enough to have been involved in the remote and rural sub-group of the work on the national framework that is led by Professor Kerr. What you describe is part of the initial thinking of that group. I honestly believe that we should consider how to grow our own staff

from local communities through educational pathways. To return to the comments that Jim McCaffery made about an academy, that could be achieved in a rural area through a virtual academy. People could be linked into educational frameworks using existing technology. However, a lot of education can be done locally—that should be retained and people should be networked to other resources only when we must do so. We must ensure that an educational framework goes along with that. Thinking is moving in that direction, but we are only at the thinking stage on the generality, although examples of such systems exist.

Mike Rumbles: On rural communities, I have a quick example that relates to the response that I received earlier to my question about GPs. The Royal College of General Practitioners states that we will be short of 500 GPs in eight years. In response, it is argued that to tackle the problem we have a new way of working—we have the allied health professionals, nurses and everybody else.

My example relates to out-of-hours work by GPs in Braemar, where the health board said, "We can cope, we can cover it." However, that is where the only doctor who opted out of the service practices. Why is that? Not only does he consider the new way of working to be unsafe, the entire community considers it to be unsafe. In areas such as Braemar, where the majority of the community comes to public meetings to voice their concerns, the argument is not being won by the health professionals, and I am not convinced by it. What needs to be done to convince the general public that those new ways of working are safe and that one does not necessarily need to see a GP in a remote and rural area? The public perception is that we are short of GPs and that we must not only address outputs, but inputs too.

Dr Ingram: I cannot comment specifically on the situation in Braemar, but my general view is that we all have a role in working with the public. I include all the clinicians in all the clinical groups.

15:15

People will be frightened of change—it is well known that people are uncomfortable with change in every aspect of life. If there is a change model in an area, the proof of the pudding has to be in the eating. People have to feel safe. Equally, the clinician who devolves duties to someone else has to feel that that person can safely deliver what has been devolved to them, and thereafter offer support. If one professional group says that that is not a good way to deliver care, it will be difficult for the public to then believe that it is a safe way to deliver care. We have to develop ways of delivering care that stand up to scrutiny, that are demonstrated to be safe and for which we can develop evidence to prove that they are safe.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): The majority of the work needs to be done by nurses because we do not have enough doctors. I feel sorry for some nurses—they are not all happy with their lot or with the changes. Those who go into NHS 24 and get an upgrade and better conditions are happy and those who work in accident and emergency departments in upgraded posts or as nurse practitioners are happy. When we were in the Hebrides, we found that when people were given extra tasks and the chance to become multiskilled, they were happy.

However, some people are left to look after the jobs in the wards, which are understaffed. What work is being done to improve their lot? Too often people complain that there are not enough people to keep up standards of nursing at ward level, that grievances are not dealt with quickly and that if private agencies can deliver what people desire, the moving population of nurses all go to agencies. What are we doing to supply the same joy of flexibility to the moving population of nurses and the nurses who live in our cities? When one hears from nurses on the job—whether in the Outer Hebrides or in Glasgow—they say, "Agency nurses come in and get paid a lot of money. They get paid more than we do, but they don't know the patients or the job so well." What work is being done in this sore area?

Patricia Leiser: You have covered a number of issues, but the core point is that we must ensure that nurses are valued and that their role and significant contribution are valued. We have heard several witnesses say that the new arrangements will allow a doctor to do what a doctor is good at.

It is clear that the nursing profession makes a significant contribution, but some nurses are concerned about that contribution being diluted because, in addition to their nursing role, they have to operate down rather than across. What I mean by that is that they might have to pick up some duties—either on a ward or at community-team level—that someone else could do. That goes back to my earlier point about the whole work force. It is important that we ensure that care workers, for example, are part of that multidisciplinary team so that some of those duties are picked up by that group of staff. The value of that would be that nurses would be able to concentrate on the contribution that their training has equipped them to make.

That is a fundamental point and there are several examples throughout Scotland of where such support is being targeted. That adds to the wider demography issue; if we have a shrinking population in Scotland and Europe, we will be able to target some of the areas in which we are not

currently recruiting. In the east, north and west, there are examples of targeting long-term unemployed people, for example, to ensure that people from a broader range of backgrounds are coming into the NHS. We need to broaden access.

The Convener: We need to wind up this section. Will the witnesses please be brief?

James McCaffery: We are conscious of the agency staff situation. We have already stopped taking on unqualified agency staff in the Lothians and we are committed to minimising, if not to eradicating, the use of agency staff in the next year. One thing that you must realise is that most of the agency staff are our staff who go to work through the agencies and on our bank. Therefore they are a known work force. However, we are not unaware of the issue and we are spending a lot of time with the nursing directorates to resolve the problem.

The Convener: I thank the three witnesses on the panel for coming in to give us evidence this afternoon. We will have the minister after this. If members have further questions, we will follow them up in writing.

I suspend the meeting for two minutes so that we may prepare for the minister.

15:21

Meeting suspended.

15:24

On resuming—

The Convener: I bring the meeting to order and welcome the Minister for Health and Community Care. I invite him to make a brief opening statement before we move on to questions.

The Minister for Health and Community Care (Mr Andy Kerr): I will take a few moments to put the matter in some context. I welcome the committee's work on work force planning, and I will explain some of the progress that we have been trying to make on planning for the future of the work force in the health service.

I have watched and listened to the committee's deliberations and it is clear that there has been weakness in respect of the work force in the health service—we are trying to address that. Historically, work force planning has been variable and I accept that the links between redesign of services and planning for a changing work force have not been strong. We are trying to resolve those difficulties. The evidence shows that the issue is complex: it is simple to say but difficult to do. Some of the evidence that the committee has been given points to that complexity. Likewise, it is not an exact science, as I think that the witnesses from whom you have heard would agree.

However, we have begun to tackle the problem and we have put in place structures to deal with the issues. Documents have been prepared and published and progress is being made. The work force numbers group, which is chaired by Mike Palmer, is overseeing work force planning at national level and it reports to our national work force committee, which is chaired by Mark Butler—both are with me today, which is useful. The work force co-ordinators, from whom you have just heard, are taking matters forward at regional level and are working with Mike Palmer and Mark Butler to ensure that planning is developed at board level.

We are thus delivering, I hope, a comprehensive and consistent approach at national, regional and local levels that projects and aligns work force supply and demand issues and links them with service planning. In that way we will be more able to secure an efficient, effective and well-motivated work force in the health service, which is what we all aspire to. All the sectors and interest groups from which the committee has had witnesses—and more—are involved in the process which, I argue, is still evolving. Involvement will continue and enlarge. I am glad to say that the Academy of Medical Royal Colleges recently agreed to join the work force numbers group.

The solution will not be an overnight one because this is a complex area—it is a long-term issue and an iterative process—but we seek to improve how well we do the task year on year. In my view, and that of other witnesses from whom you have heard, we need to reflect changes in service delivery in terms of where the health service is heading in the broader sense, and changes in society in terms of age profile and demographics, both of which have clear implications for work force planning. We hope that the arrangements that we are putting in place will deal with some of those challenging issues.

Many factors must be taken into account: supply and demand; changing needs in health care; health and safety requirements; working time limits; medicine and technology advances; modernised training programmes; new roles for nurses, paramedics and allied health professionals; changing work patterns; the profile of the work force; and Scotland's population and health needs. As Professor Sir John Temple said in your first evidence-taking session in an important comment, the health care system that we have will not be suitable for delivering health care in the future—we have to change it. The work of Professor David Kerr on the national framework also helps to inform that work.

We published a national baseline report on the work force, which set the scene and kick-started the increased activity on work force planning. The

2005 Scottish health work force plan, with a projection of future work force needs, will be produced next April. Regions will also produce their baseline reports then, followed by regional work force plans. That work will set in motion the actions that we need to take to secure the right people with the right skills in the right place at the right time to deliver health care that meets the needs of the people of Scotland, which is our intent. We acknowledge that we should have been doing better, but we are now addressing some of those difficult issues.

Mike Rumbles: I refer you to some of the evidence that we received from the Royal College of General Practitioners, whose submission to the committee said that we will be about 500 GPs short during the next eight years. In my question to Dr Scott of the RCGP, I asked:

"If the Scottish Executive funds the recommended number of 100 a year, will that solve the problem in the long term?"

I refer to the Calman review and the recommendation that you should accept an increase in training places of 100 over and above the 700 places that we already have. Dr Scott replied:

"No, that would not solve the problem in the long term, because those extra 100 doctors would not all be general practitioners."—[*Official Report*, *Health Committee*, 26 October 2004; c 1293.]

The Royal Colleges say that we have a real problem.

Calman's expert group has said that we need at least 100 more doctors. We have heard that the decision rests with the Scottish Executive and, in effect, with you. I am not asking you to say "yes" right now to the Calman review, but will you indicate whether you think Calman is on the right track?

15:30

Mr Kerr: For me, the more important thing that Calman had to say was about retaining people in the health service. We train a great many doctors here in Scotland—some 900—and retention and recruitment into the work stream is important, whether those people come from Scotland, the rest of the UK or the rest of the world. We have to retain many more of our graduates.

Before I come to the crunch issue of numbers, I should point out that the discussions of the Royal College of General Practitioners have been about the health service as it is now; we will have to involve the college in more discussions on what the health service might look like in future.

Other witnesses have spoken about the broader health work force team. Changes mean that people are now doing different tasks in different ways; everybody's role in the service is being challenged. We now have nurse clinicians, midwives who are adding to their skills and GPs who are completely changing how they work locally.

As I have said before, the issue is not about taking a sectional perspective of where our work force is going. We have to consider where changes in the health service are taking us with regard to the work force that we need. Calman talks about retention and about ensuring that more Scottish students come into the process. We also need to consider more fully what the shape of the health service will be in five, 10, 15 or 20 years.

We will consider the numbers once such issues have been resolved. I do not automatically sign up to the view of the Royal College of General Practitioners on the matter and I would challenge some of its assumptions on the future of the service, but we will of course respond to Calman in due course. Mike Palmer may wish to add something.

Mike Palmer (Scottish Executive Health Department): We also have to consider our approach to the training of general practitioners. In the context of modernising medical careers, which is about the new pathways to training in the medical work force, we are considering how to make the training of GPs more attractive to trainees, offering a pathway that they want to take. GP registrars have felt that they have not had adequate time in their training under the current arrangements. The modernising medical careers delivery group is ensuring that we address the training needs of GPs. We have to take the cohort that we have at the moment—that broad medical student pool—and ensure that the way in which we distribute those people, across different medical pathways in general practice or hospital careers, meets the needs of the NHS in Scotland as effectively as possible.

Mike Rumbles: I would not disagree with anything that has been said about the importance of retention, but the evidence that the Royal College of General Practitioners has presented is clear. Over the past 10 years, we have been producing an average of 270 GPs a year. In the 10 years before that, the average was 318. The problem is not new. The figures go back over 20 years, so I am not laying the blame at the Executive's door. The royal college has also said that the structure of the work force has changed. Twenty years ago, 40 per cent of the work force was female; the figure is now 66 per cent. Females take more career breaks than males; that is an established fact. The figures show that we cannot resolve problems simply by making better use of the present resources. We will have to take the plunge and get more GPs into the system.

Mr Kerr: I cannot remember the witness's name, but I am sure that I read somewhere in the committee's previous deliberations that there may be an oversupply of GPs in certain areas.

Mark Butler (Scottish Executive Health Department): It was the witness from NHS Education for Scotland.

Mr Kerr: Yes—although I cannot remember the chap's name.

Mark Butler: Malcolm Wright.

Mr Kerr: Yes, Malcolm Wright.

There are contradictory views out there. The issue is not about creating silos and saying that the problems are just to do with physiotherapists, general practitioners or consultants. It is about how we see health developing in future and how we can best fit the work force to the service. The role of the GP is changing dramatically. The new GMS contract enhances GPs' role and changes what is happening in our local communities. Contact with the health service at a local level is increasing, not decreasing. That means that roles change.

As we plan our work force, we need to get the mix of clinical skills throughout the health team. I am not saying that others are wrong. I am saying that, just because they say something, that does not make it true, and that, just because they may have taken a snapshot of how they see health now, that does not mean that that is how health will be in future. That is why we are here: it is to do with work force planning.

Mike Rumbles: The Executive wants 600 new consultants, 1,500 new allied health professionals and several thousand new nurses and midwives. I applaud all that because the Executive is recognising not only that it has to make better use of the people that it has now, but that it has to recruit more people. The Executive recognises that with nurses, midwives, consultants and dentists. However, Calman then says, "We need 100 new doctors," and suddenly I am detecting people thinking, "Well, actually we need to concentrate more on retention." Am I wrong? That is what I have understood from the evidence.

Mr Kerr: I think that you are trying to lead me down a path towards saying, "I do not agree with Calman."

Mike Rumbles: I would not do that, minister.

Mr Kerr: I am not saying that, however. I am saying that we need to carry out our service planning analysis to ensure that the numbers are accurate for what we need to do. If we improved retention rates for those who have been trained in the system, we would solve a big problem in the Scottish work force. All I am doing is trying to balance the discussion about the assessed need, the assumed need and the thinking that results from our work force planning mechanism. The discussions that Mike Palmer has with colleagues are to ensure that we get the numbers right. I am not saying that they are not right; I am saying that we need more rigour in the planning process. That is why we are here.

The Convener: To advise committee members, I will quote what Malcolm Wright said:

> "we have increased the number of GP registrars who are going through the training schemes. We are slightly over-established for those posts at the moment."—[*Official Report*, *Health Committee*, 2 November 2004; c 1356.]

Shona Robison: A consistent issue in today's evidence and other evidence is the lack of a clear service plan. The royal colleges said today that we need to know what sort of health service people are to be trained for. You acknowledge that the Executive should have been doing better—I think that you are right on that point. However, something in the Scottish Executive Health Department's submission for today's meeting concerns me more than a little. In paragraph 6, on recruitment and retention difficulties, the submission says:

> "Staff increases are being delivered across staff groups, reflecting the Executive's Partnership Agreement commitments".

It then adds, in brackets:

> "although it is important to note that delivery of targets on staff numbers is complicated by the fact that the recruitment and retention of staff is an operational NHS employer responsibility under the control of NHS Boards, and subject to the operational and financial priorities faced by Boards."

That suggests to me that the targets that you have set in the partnership agreement may not be delivered, due to the financial priorities—or, indeed, the financial difficulties—of health boards. Yet again, as the submission suggests, we see other issues coming into play that are beyond the Executive's control. However, we are talking about a clear necessity for a national planning strategy to get the work force right. How do you control that process?

Mr Kerr: I accept that we could have been doing better with regard to work force planning, but that is not to say that there has been no work force planning. We have a fairly sophisticated nursing and midwifery planning model, which involves a five-year projection that is updated annually and tries to take cognisance of changes in the balance of skills within the service. The same applies to diagnostic specialisms in the service, because we acknowledge that we have problems in relation to diagnostics.

The numbers did not appear out of thin air. They are the result of informal contact—that could be

more formal—with health boards about what they consider to be pressures in their areas and of our picking up pressures in the system nationally. From that, we develop our health service targets and commitments. The targets are not foisted on health boards. We discuss them with health boards regularly, so the expectation is that they will be achieved, because the local dimensions have been agreed locally. Both sides are committed to ensuring that that happens and the required resources have been provided.

However, I have no control over whether a doctor or a consultant works in a practice or a hospital. Recruitment is the job of health boards, although we give guidance on that and set performance targets. We are trying to balance our work force with the performance targets. My colleagues who have closer daily contact may want to add to that.

I am confident that our targets can and will be met, because they did not appear out of thin air. They resulted from a process of consultation and discussion and were considered in relation to what we want our health service to achieve and what we need to enable that to happen. The targets were not foisted on health boards and did not pop out of thin air.

Shona Robison: I am not suggesting that the targets appeared out of thin air; I am saying that your officials' words suggest that meeting your targets may be a problem because of what happens locally. We know that health boards' financial difficulties are likely to worsen. Some dispute exists over the figures, which are being examined, but most people would acknowledge that significant financial pressures exist. You can set all the targets you like, but if health boards cannot deliver on them—if I read the submission right, officials say that health boards might not deliver because of financial difficulties—does that not blow a hole in the strategy that you are right to try to set nationally for delivery of the health service that we need and the work force that we need to staff it?

Mr Kerr: No. The submission recognises what happens in the real world. I am saying that we have agreed the work force targets and that we expect health boards to deliver. You are referring to what is just a statement of fact about my powers and the powers of board chairs and chief executives, whom I have told that I expect our targets to be met.

Mr Davidson: I wish to understand the weighting of the advice that you receive, because you sound as though you are passing the buck to health boards to deal with problems.

Mr Kerr: I pass resources to health boards to deliver the health service; that is not passing the buck.

Mr Davidson: You will not be involved in work force planning.

Mr Kerr: That is not correct. In my answer to Shona Robison, I tried to explain where the numbers came from. We are trying to create national, regional and local work force plans. Executive officials are hugely involved in that task, but it also involves work locally. The committee heard from regional planners earlier about their role in that. We are not passing the buck. We accept that we need to fill a gap in our knowledge of what the work force should be in the future and the only way to do that is to work locally and regionally with our health board partners.

Mr Davidson: The royal colleges were a bit worried about the level of advice that they give, although they were clear about the professional advice that they give. How much do you listen to the colleges' advice and how much will you listen to Professor Kerr? When you have listened, what decisions will you make, and when? We need a timeframe. You said that retention is a big issue, yet you have commented on it little before today.

15:45

Mr Kerr: The health service is a huge subject. I could mention many topics that people might think that we were ignoring—although we are not—had I not mentioned them.

Your first point was about the royal colleges. I made it an absolute priority to meet postgraduate deans and the royal colleges—those meetings have taken place—to ensure that we reach a common understanding of how we seek to improve the health service in Scotland and of the challenges that we face. The royal colleges are integrally involved, as they always are. Graham Teasdale and others told the committee that the role of the colleges is to ensure that training is provided appropriately on site. Our job is to ensure that there are enough trainees in the system, which is what we seek to do. There will always be discussions about the matter and I accept and understand that trade unions and royal colleges will always argue for more for the professions that they represent. My job is to consider the right balance for the health service in Scotland, through work force planning.

Where are we and where are we going? We have published the "Scottish Health Workforce Plan: 2004 Baseline" and local baselines are being developed. By April 2005, we want to have a plan that will set the strategic context for where we envisage the work force heading and that will try to balance some of the pressures in relation to the increasing localisation of health care and the specialisms that must be delivered. We are fully engaged in the process and we try to involve

everyone. We have made strategic interventions in the past and we will do so again.

There are problems with diagnostics. We are increasing the number of radiographers, we are providing resources to increase the numbers—there is now a second cohort of 30—and we are increasing student numbers in the allied health professions, including an initiative to bring in an extra 65 staff. We are doing that because there are difficulties in the system in relation to diagnostics and in relation to how we envisage the future of a health service that will try to keep people out of the acute hospital sector and treat them locally and in the community. That is why we have constantly tried to manage and shift the work force.

When I became Minister for Health and Community Care, I was surprised to find that such a level of planning was not a matter of course throughout the health service—I am sure that that also surprised Malcolm Chisholm when he took up the post. We are trying to solve that problem. I respect and agree with the view that we should have done so earlier, but people should not make a huge leap and suggest that we were doing nothing before. We have been working on the matter. Our nursing plans are well developed and provide a good benchmark for us to follow.

Mr Davidson: May I pick up on a comment that I think you just made? I understood you to say that it is your job to sort out the numbers of trainees, irrespective of where they are placed. What plans do you have to do that and what tools will you use?

Mr Kerr: That is a work force issue; it is not about any particular sector of the work force. We need to provide the structure—David Kerr is currently working on the structure. How do we envisage our health service in the future? If we speak to A and E nurses, nurse practitioners or staff in local health centres, it is clear that what those people are doing is radically different from what they were doing two years ago. I spoke to a veteran senior A and E nurse with 30 years' experience, who told me that there are huge differences between what she does now and what she did when she started her training. Those changes have not just come about over 30 years; they have also happened over the past two years or the past year.

Through the work of the Kerr group, we will try to get a perspective on where health care is heading. We need to determine complex and difficult issues around maximising local provision that is as specialised as is necessary. There are problems in the service, such as the problems with diagnostics. We must consider how to deal with such problems and we must ensure that, as people progress through their careers, the right numbers are in the right place at the right time. That is what the process is about and those are the decisions that we will take in the work force planning environment.

Mr Davidson: I am sorry to push the point, but I asked what tools you have at your disposal to increase numbers of trainees, regardless of the sector that they happen to be in.

Mr Kerr: Do you mean the diagnostic tools? I am not sure what you mean.

Mr Davidson: You said that it is your job—I think that you said "our job"—to provide the right numbers of trainees, regardless of where they go. What tools do you have at your disposal for that?

Mr Kerr: The tools that we use are, for example, the ability to increase the number of available places through the education system. We can increase the numbers of nurses. We can work with the Scottish Executive Enterprise, Transport and Lifelong Learning Department through the Scottish Higher Education Funding Council and others to ensure that places are available. That is the key tool that is available to us. Mike Palmer might add to that.

Mike Palmer: As the minister said, there are targets in the partnership agreement. Clearly, we want to achieve those key objectives, so we want to prepare the training pathways to supply the bodies—so to speak—to hit those targets.

I will describe the processes and systems that we have in place to do that. I chair the national work force numbers group, which involves employers, NHS Education for Scotland, the regional work force leads from whom the committee has just heard and a number of other stakeholders. The group is overseeing the process of determining the number of training-grade doctors that we need for the future.

At present, the medical work force is in a period of transition because we are moving towards the different set of training pathways outlined in modernising medical careers. With NHS Education for Scotland, and with input from employers and others, we are scoping the work force consequences of modernising medical careers and we are identifying the numbers of training-grade doctors that we will need to go into the different foundation and run-through programmes. I am fairly confident that we are at least at the forefront of the UK, if not ahead of the rest of the UK, in doing that work.

The department determines the number of training-grade nurses through the nurse intake programme that the minister mentioned. A broad reference group of stakeholders, including the Royal College of Nursing and representatives of the profession, brings forth recommendations on

the number of student nurses that we should take in each year. At present, we have record levels of student nurses, because the projection that we made through the reference group process is that those levels are required to supply our needs. A very robust process applies to that pathway.

We have specific and dedicated processes and systems to determine training-grade numbers. The issue is slightly complicated for the medical work force because we are moving from a system of senior house officers and specialist registrars to the new system of modernising medical careers.

Mr Davidson: We will assume that there is a budget for that.

Mike Palmer: Yes. There must be alignment between the funding and the numbers for SHOs and specialist registrars, for example, through NHS Education for Scotland.

Janis Hughes: I want to follow up on the issue of recruiting, training and retaining nursing staff. The Royal College of Nursing gave evidence that the Executive's commitment to training, recruiting and retaining 12,000 nurses might not be sufficient to bring Scotland into line with the rest of the UK, although earlier today the work force planning people told us that the target is okay. In the light of the initiatives that are coming on line that allow nurses to extend their role to deal with issues that relate to reducing doctors' hours, does that target still meet the requirements for future work force planning?

Mr Kerr: I have not been advised otherwise. As far as I can see from the figures that are available to me, that is the case. The initiatives that Malcolm Chisholm launched, such as the return-to-practice initiative and the initiatives on upskilling and enriching the job, contribute to retention. Loss rates are remaining stable, although we clearly want to build on that and increase retention rates. I have no reason to believe that the target is not sufficient.

Mike Palmer: We are running on maximum in getting nurses into training and getting the supply through. Our assessments show that we will exceed the recruitment target of 12,000 nurses. We deliberately decided to have the maximum level of training places. The number of clinical placements that we can give student nurses is almost at saturation point. We took that decision consciously and deliberately because we feel that it is important to ensure that the work force will be sufficient for future need.

Janis Hughes: What new measures are being put in place to ensure that we retain nurses when they have gone through the training system?

Mark Butler: One principal way in which we can retain staff is to ensure that they are clear about the career opportunities and pathways that are in front of them. That depends on the nature of the skills that they develop and on how they play into teams, in the acute sector or throughout the service. That work needs to be done with the front-line staff and that is the commitment that we are making.

In the discussion that we have just had, all those issues sound quite centralised, because we are talking about the formality of planning. However, the real engagement about retention is with our staff. We provide good working lives for them, they are clear about the career opportunities that exist and they are supported in their clinical professional development. All those commitments are in "Partnership for Care: Scotland's Health White Paper" and they are being seen through.

Work force planning never sits on its own. It is part of an overall process that has to work and to be aligned at national, regional and local levels not just with service planning but with the key issues that define services in terms of teams and that define teams in terms of skills. That is an enormous change of culture for the NHS to achieve and we should not underestimate the scale of it. It is not necessarily about programmes and interventions. It is about our whole approach to the hearts and minds of the staff. We recognise that there is as much work to do on that as on the technicalities of planning. We should not underestimate those commitments when we talk about work force planning. The engagement with front-line staff through partnership processes, which are extremely well developed in Scotland, is a major priority for us and it runs in parallel with everything that we have discussed so far.

Janis Hughes: There are new opportunities for nurses to extend their roles. Does that have a bearing on the retention of staff?

Mark Butler: Yes, of course it does. The issue is about engaging with staff in working through what the service needs to look like and the quality and safety of the service. Professional staff need to feel that they are part of a system that works well; they need to see their part in the system and how it will play out in the years ahead. The challenge for us is to get to that point much more consistently. When we engage with staff across Scotland, we see that the picture is patchy. To a certain extent, we would expect that in a service of such a size, but we have to make sure that there is much more consistency by working with staff, their representatives, the professional organisations and the colleges. We need to get the shared intent in place and to ensure that the traditional boundaries between professions are actively worked across and seen through by those who represent the professions and those who are trying to work through the difficult and complex

issues relating to what the future of the health service should look like.

Dr Turner: On retention, an important area is accident and emergency departments. In Glasgow, we are desperate for A and E consultants—it might be that Glasgow does not have the money to give full-time jobs to the seven, eight or nine staff who are in the pipeline and nearly ready to come on stream. How can you help? A casualty department such as the one at Stobhill hospital, even though it is not a trauma unit, cannot be run if it does not have enough A and E consultants and it could close. Can you intervene in any way? Glasgow is strapped for cash.

Mr Kerr: Everyone in the public sector should treat their money as wisely as possible. I expect there to be stretch and tension in any financial system in the public sector, because it is the public's money that we are dealing with. I expect Glasgow to plan its work force and deliver the required service. I am happy to look at individual cases that are brought to me, but my general response to your question is that resources are provided through a formula, with which we are all familiar, and national initiatives are funded. On the key issues that you raise, financial resources should not be the sole determinant of the delivery of services. We will always have recruitment difficulties because of competition in the marketplace and because of people making decisions about where they want to work and live. I hope that Greater Glasgow NHS Board—and indeed every health board—has adequate resources to fulfil the health service's requirements and I see no reason to think otherwise.

Dr Turner: The worry for me is that if the board did not have the money and did not employ these people there would be serious implications for a big city such as Glasgow because certain hospitals could not be kept open. That leads on to the fact that we might have a diminishing population but casualty departments have an increasing work load. Multisystem problems cannot always be treated in general practice so people come along to casualty or accident and emergency departments. They require expertise and input from consultants, not just from nurses, and the need for beds is associated with that. How far down the line are you with figuring out how many beds we need to allow those people to be admitted to hospital?

16:00

Mr Kerr: In relation to the consultants and the work stream, the point of work force planning is to ensure that those people are available to the service. Whether we are talking about Glasgow or Wick, or the north, south, east or west of Scotland, those tensions in the system around attracting, recruiting and retaining the work force will always exist. What we are trying to achieve, through the increase in consultant and AHP numbers, is a reduction in that tension. I do not share your pessimistic view about those issues. As some witnesses have said, health boards have, and will continue to have, continual turnover, because people want to move on, to develop professionally and perhaps work in different countries, never mind different parts of Scotland. We just need to deal with that process and ensure that our services are reconfigured in a way that provides the services that people expect, while providing exciting opportunities and addressing the retention issues that we seek to resolve. That is how we will continue to address that problem.

There are projections on the beds issue. For example, the British Association of Day Surgery says that, in 10 years' time, 90 per cent of operations carried out will require a hospital stay of less than 24 hours. The beds issue is exactly the kind of issue that we need to deal with through work force planning. Different needs will arise in the development of the service, more matters will be handled locally, acute services will change their shape and accident and emergency will become a different type of service. With the aging population there will be a reduction in episodic events in the health service and more chronic disease management. We need to plan the service to deal with that—that is why we are here. The situation is difficult; nonetheless we are aware of the problem and of the data deficit in our systems. The work of my colleagues here, plus all our partners in the health care team, is aimed at trying to resolve that.

Dr Turner: The knock-on effect of having too few beds is that staff are demoralised by constantly phoning round the city to pass the parcel of patients. Do we have a robust model for working out how many beds we have? Are we trying to project how many beds we need in a city?

Mr Kerr: The boards do bed projections day in, day out. I acknowledge that it is a very tight system, but a tight system is one that can provide the required care efficiently and economically. The more out-patient activity we are involved in, the more the beds debate becomes a different debate that is centred on the actual number of beds that we require.

Mark Butler: I appreciate that the currency of beds is important—it is certainly fixed in people's minds. If we are really going to do work force planning well and concentrate on making the skills that are needed available when they are needed, we have to move to a description of service that is not dominated by acute episodes of care. We have to consider maximising the benefits that are

built into the investment that has already been made, for example in pay modernisation, in the GMS contract, in unscheduled care and in chronic disease management. The board should also focus on those issues. The domination of some short-term goals can prevent us from getting to the point at which we have sustainable services. It is the service currency rather than the bed currency that will show that we are in the right territory for the future.

Mr McNeil: The minister mentioned that this is a complex issue, and anyone who has taken an interest over the piece and who has heard the evidence would agree. Simply recruiting doctors and medical staff does not necessarily resolve matters. In our papers today there are examples that illustrate that the challenges people such as the minister are facing in delivering services are fairly common throughout the world. The common feature in most of the countries mentioned is that they recruit doctors from abroad to deal with the shortfalls. That will always happen, whether it is a shortage of paediatricians, a shortage of people in accident and emergency or a shortage elsewhere. However, people cannot be forced into the areas where there are shortages. In other countries, an essential part of the services delivered and of the planning process is plugging gaps—either short, medium or longer term—by bringing in people from abroad. What work has taken place to roll out such a programme in Scotland?

Mr Kerr: We have a long record of recruitment from all round the world. I accept that it is a two-way street and that clinicians from Scotland go elsewhere to work, where they pick up new skills and ways of working. Likewise, folk come to Scotland. The process for recruiting non-European staff is fairly rigorous. Although there are agreements and understandings about skills in Europe, non-European skills must meet strict BMA and other professional requirements.

The issue here—this relates to the fresh talent initiative—is about how we help people to come to Scotland to work and about how we assist them not just with the job, but in other areas of life: with schools, nurseries, support systems, housing and all the other things that are important. That is how we will retain indigenous public servants and recruit and retain people from elsewhere.

I defer to my colleagues about work force planning.

Mike Palmer: We have a long history of international interchange and collaboration with other countries, particularly in the medical work force, but in other staff groups too. There is a constant flow of overseas staff into Scotland and, vice versa, Scottish professionals go overseas.

We have support in the department for NHS boards that wish guidance and support at the national level on overseas recruitment. We have established initial links with countries such as Spain, China, Poland and the Philippines and with European Union countries. Our doors are open as far as the ethical recruitment of overseas staff is concerned. That will be a factor in the preparation of the next work force plan that will come out next spring. There is an important element both in the training grade medical numbers and in the trained doctor cohort from overseas. We do not wish to ignore that; we wish to embrace it and to factor it into our planning. We are certainly bearing that in mind in the work that we are doing.

Mr McNeil: That response does not sound enthusiastic. We are constantly told that the health services in Australia, Canada and Scandinavian countries such as Sweden and Denmark are wonderful. Where is the enthusiasm here? What are the difficulties? What are the barriers to actively recruiting people from other countries to come here and fill the gaps? Perhaps we need more information about what is being done. You told me that exchanges were in place and so on, but your response did not seem enthusiastic—we are not out there recruiting people who are prepared to go to other countries.

Mr Kerr: With due respect, when the First Minister launched the fresh talent initiative, we had applications from all round the world to work in many public services, but in the health profession in particular. When the Stonehaven dentist story got out, dentists contacted us from all round the world.

In the fresh talent initiative, we are trying to say that Scotland is an attractive place to work in that offers quality of life, education and skills enhancement. We use that to market ourselves aggressively, but in a focused way by trying to build up contacts and relationships with other nations. Perhaps, given the warmth of the room and the time of day, we do not appear to be enthusiastic, but you can rest assured that we are enthusiastic and that recruiting from overseas has always been part of our strategy.

The Convener: I will take up Duncan McNeil's point. Of all the dentists who were desperate to come to Scotland and who registered an interest in doing so after the publication of the Stonehaven story, how many have actually come to Scotland?

Mr Kerr: I would need to find out from the fresh talent office what happened with the engagement that we had with them. The vice-consuls that I have met have said that good discussions are going on.

The Convener: If concrete information exists, we would all like to see it.

Mr McNeil: We would like to know what is being done actively to recruit people, how many people from abroad are working here and what the potential is to have more such people. That would be useful.

The Convener: It would be extremely useful, because at present we are not clear about the numbers.

Mr Kerr: Okay. We will provide that information.

Kate Maclean (Dundee West) (Lab): I want to return to an issue that either Shona Robison or David Davidson raised and which is the crux of the matter. We have heard a lot of evidence, both during our visits in the summer and in committee meetings. In general, most people welcome the fact that the Executive will take control of training numbers. However, a point that you did not answer properly earlier was that, at the end of the day, it is up to the NHS boards to manage their operations in line with their finances. The Scottish Executive can direct more training of much-needed professionals in all disciplines, but what can you do if NHS boards do not have sufficient funds to employ people? Many boards are either in deficit or will go into deficit and one of the ways in which they try to balance the books is by not filling vacancies, which means that people are not actually in post doing the job.

Your response to, I think, David Davidson was that a budget is available for boards to meet Scottish Executive targets on the issue, but that is not the evidence that the committee has heard since I have been a member. You said that national initiatives are being funded, but there is no evidence to back that up. I am concerned that the NHS boards will get the blame for not delivering Scottish Executive policies, even though they do not have a sufficient budget to do that. Will you respond to that point, because I am not clear that you responded to it earlier?

Mr Kerr: I will try again and, I hope, reassure you. The targets and objectives for the standards to which we expect our health service to work are publicly available. We are required to resource that through the provision of money and people, in which the health boards have a critical role. If, after an analysis of the information that we receive from the health boards, we assess that, for example, we are not taking on enough radiographers and that we have a difficulty, we will put more resources into the system through the work on education.

I expect boards constantly to reconfigure and modernise their services, which they do all the time. Patient-centred booking systems, which reduce wasted time in the clinical environment, are now used and services, such as those for out-patients, are provided differently. Those are all additional changes that can be made to the system in order to provide a better service. On top of those changes, we have record-level increases in the budget. I never talk about the big numbers, because they do not mean anything to people any more. When we talk about £10 billion for this and £100 million for that, people do not get it, which I understand. They expect a certain service level, which includes waiting times, targets and how the local system works. In some areas, we do extremely well, while in others, we do not do so well. We work together with the boards on the targets and we issue the resources through the system partly using a formula that is based on the health make-up of communities. The resources then go into the system.

A 33 per cent increase in resources has been required to fund the new GMS contract, and other issues arising from the agenda for change require resources. There will always be pressures, but that is right, because we must ensure that the public pound is tested in every way, that priorities are set appropriately and that resources are spent wisely.

I acknowledge the tension on that in the system. We try to help centrally through the funding that we give our health boards. I expect no health board chief to say, "Thanks very much—we have plenty of money now and we will get on with it," because they want to do more, and we want them to do more. The health budget has an envelope but it has grown massively in the past five years. Where do we stop?

16:15

Kate Maclean: Was that a yes?

Mr Kerr: It was a yes to the question whether we work with health boards on objectives, targets, resources and how we deliver the service, which we fund them to deliver.

The Convener: We have only five minutes left of the time that we allocated for the session and several members still want to ask questions, so I beg them and the witnesses to be as brief as they can be.

Shona Robison: Mark Butler referred to exceeding the target of recruiting 12,000 nurses. The RCN said that that target would create a standstill position—I will put that aside—but it also cited cross-border flow. The Executive's submission says:

> "A further pressure is exerted at UK level, where Scotland is competing with aggressive recruitment of nurses and doctors in England."

What aggressive recruitment of doctors and nurses has NHS Scotland undertaken in England?

NHS Education for Scotland told us that when someone is about to qualify, no interview is held to

keep them in Scotland. Why does that not happen?

Mark Butler: I understand that such interviews now take place. Engagement with people not only in nursing, but in training, and making the connection between trainees and their aspirations for a career in Scotland or elsewhere are being more actively managed than they were in the past. I am not saying that that stretches back five or 10 years; it has been a response to the asking and pursuing of questions about what is actively being done.

As for active recruitment, I do not think that recruitment is an issue of competition just with England. The initiatives that boards up and down the country have put in place aim to engage actively in nursing in an international market.

Shona Robison: Your submission cites the

"aggressive recruitment of nurses and doctors in England."

How is the NHS in Scotland aggressively recruiting in the other direction?

Mark Butler: The point has been made that boards need to sell their local communities, environments and working environments to the nurses whom they need to recruit, whether they are from England or the Philippines or elsewhere in the international market. The evidence is that when boards have done that, they have succeeded. Our role is to ensure that the right quality and standard of nurses are available in Scotland to provide services and that the code of ethical practice is being adhered to so that service quality does not diminish.

We would not gain much simply by exchanging nurses across the border. Our focus is—rightly—on doing what can be done in the short term to plug gaps. The real issue is making the NHS Scotland brand into the brand of choice for nurses wherever they are in the world. The boards are actively pursuing that.

We have established a recruitment and retention unit in the Executive that is tying those initiatives together and looking to make online recruitment, for instance, a simple matter for any health staff who wish to work in Scotland. That will be one of the main features that we market in the next few months.

One aspect is making Scotland attractive, as the minister suggested, but, in the end, the selling process to ensure that the right staff are present must be a local as well as a national matter.

Shona Robison: Will you write to tell us the number of health boards that have gone to recruitment fairs in the south or internationally to recruit nurses and doctors actively?

Mark Butler: We can provide that in addition to the international recruitment information that has been requested.

The Convener: If Mike Rumbles is very quick, I can fit him in.

Mike Rumbles: Witnesses have said that how the places for the 1,500 extra allied health professionals will be provided has not been discussed. I will give one quick example. Stephen Moore from the Society of Chiropodists and Podiatrists said:

"There is good evidence from south of the border of how the point can be reached at which it becomes difficult for patients to access services so that they are forced to seek services from the private sector … Unfortunately, there is evidence that Scotland is following that path and that services are becoming increasingly restricted. One challenge that we face is that the Scottish Executive does not have a view about the make-up of or access to podiatry services."—[*Official Report*, *Health Committee*, 26 October 2004; c 1328.]

Before the minister answers, I declare an interest: my wife is a private practitioner and a member of that society.

Mr Kerr: I too was alarmed by that evidence and I spoke to Mike Palmer and Mark Butler about it. We have a dedicated AHP professional working in service design and five working groups considering work force planning and how we can attract, recruit and retain AHPs in the system. We have made significant strides in recruitment in some specialisms, such as speech and language therapy, occupational therapy, radiography and physiotherapy, and work continues on that process.

I was surprised and concerned by the evidence that Mike Rumbles referred to. I think that it might be best if Mike Palmer answers the question about some of the engagement that is going on.

Mike Palmer: It is absolutely fair to say that, in the past, we have not had as good a grip on allied health professionals and work force planning for that group as we have had in some of the other sectors. We are conscious of that. We are aware that AHPs provide an extremely valuable contribution to health care and will increasingly provide a larger contribution in future.

At the most recent meeting of the work force numbers group, we had a specific discussion around allied health professions. We identified among the nine professions in the AHP cohort those that we were going to target first, because we have to do things one at a time on a pragmatic basis. We are going to focus on planning across radiographers, physiotherapists and occupational therapists initially, and then we will continue that work with the other six professions so that, by the end of the work force planning process, we will have a much better, co-ordinated and coherent view on work force planning, which we can project across all the AHP professions. Unfortunately, that

cannot happen overnight, because we are starting from a relatively low base given what has gone on in the past. However, we have made a commitment to begin that process with those first three strands. We will reflect on where we have got to in the next work force plan next April and continue that work for subsequent work force plans. We are absolutely on board in recognising the need for more coherent and effective planning around that cohort.

The Convener: I thank the witnesses for coming along. I also thank them in advance for the information that we will no doubt receive. It may be that there will be follow-up correspondence from the committee looking for further information.

16:23

Meeting suspended.

16:25

On resuming—

The Convener: I bring the meeting back to order and remind everyone that, as we agreed earlier in the meeting, we are in public session. Our deliberations will therefore be a matter of public record. I also put on record Helen Eadie's apologies for her late arrival. She advised me in advance of the meeting that she would be late today because she would be attending the funeral of one of the Black Watch soldiers who was killed in Iraq last week. His funeral is being held in Lochgelly today. Sadly, other funerals will be held in Fife over the next few days.

I suggest that we keep this discussion on our work force planning inquiry brief; members should stick to the key themes that have emerged from the evidence that we have heard to date. The idea is to give initial guidance to the clerks on the first draft of the report; we want to inform the process with our views and recommendations. This is not the way that things are normally done. Normally, we would proceed straight to the draft report stage at which point we would discuss the report for the first time. We are trying to do something slightly different. Members who want to input to the draft report need to speak up today. Do you have a question, Duncan?

Mr McNeil: Yes. Who thought that it would be a good idea to start this process at 4.30 pm after a long day? Why are we departing from the old procedures? If it is just for the sake of being different, we need to hear some justification that the idea is a good one, especially at this point in the day.

The Convener: Different committees do different things. This route has been tried out by other committees. The idea is to see whether, instead of launching straight into a prepared draft report into which members have not had early input, we find it useful to do things this way. The exercise could take five minutes or 25 minutes—it all depends on members.

The item was tacked on to today's agenda because we would otherwise have begun to run out of time. It is simply a matter of getting on with it. The discussion does not have to be incredibly long. I am, as always, in the hands of members. Members could decide that they wish to comment only in general terms on the content of the draft report.

Mr McNeil: Can I have reassurances that, although we hold the discussion today, if I get back to life between now and tomorrow afternoon—or whenever—the draft report will still be a live document into which we can feed—

The Convener: It is a live document until we decide—

Mr McNeil: It is closed after today's discussion.

The Convener: No. You are imagining conspiracies where there are none.

Mr McNeil: No, I am not.

The Convener: The discussion is simply to provide advice for the initial drafting. The draft report will come back to the committee to be discussed in the normal way. No doubt, the document will be kicked backwards and forwards. My understanding and experience tell me that there is usually about two or three week's worth of debate on this sort of draft report and it is unlikely that this report will take any less time. I simply want to try to ensure that the first draft reflects what we have said. If the process is not a good one, we do not need to do it again.

Mr McNeil: I appreciate your reassurances, convener.

16:30

Mike Rumbles: I am interested in the structure of the report rather than its detail. We said when we formulated in our minds what the report should be that we should be looking at the structure of the system. We should be asking what the people require of the national health service in Scotland. When we went around the country in the summer, what did we find that people wanted and needed from the NHS in Scotland? How are those requirements now being met? What is the system at the moment? Are the European working time directive, the new consultant and GP contracts and the royal colleges' standards the factors that are driving change? Of all the things that we have taken evidence on, what are the drivers of change?

We must also decide, having looked at all the evidence, how services should be configured as a result of that evidence to meet the needs and requirements of the people whom we talked to over the summer. That is what I would like to come out of the structure of the report, without commenting on the detail.

Mr Davidson: My points are not in any particular order, but I shall be as brief as I can and shall simply note some of the topics that seem to be current. I agree with Mike Rumbles about outside influences on the health services and how they affect work force planning, whether those influences are the working time directive, changes in contracts or whatever. However, there are issues about access to health care and where that happens—the centralisation agenda—and that is obviously linked to budgets. The number of trainees across the health service and how they are dealt with is another important issue. There will be a major section on the attraction and retention of recruits at all levels.

There is a huge issue of specialism versus generalism, which seems to be causing the profession some difficulty. We have heard a lot about the skill exchange and new working procedures, where people move into new areas of operation through continuing professional development. There is an issue about the role of the minister in work force planning versus the role of the health boards in that process. We must also take on board the role of the colleges and professional bodies right across the health service.

Shona Robison: What is really required at this stage is more of a steer than anything else, and that is fair enough. I liked Mike Rumbles's suggestions on structure, but I think that the first thing that has to go into the report is something about how we ended up here, what should have been done that has not been done and what external, self-inflicted pressures have led us to where we are.

After that, the main broad areas, as has been said, will be recruitment and retention difficulties and solutions, training and education difficulties and solutions, and some specific recommendations. It would be good if we could offer some solutions—although not necessarily i's-dotted-t's-crossed definitive solutions—that should be explored on the basis of the evidence that we have heard. That could feed into what Professor David Kerr is doing, so we should make some specific recommendations on things that we think need to be done as a matter of urgency and also in the medium to long term.

The Convener: Before I bring in Kate Maclean, I should say that we had understood that David Kerr would be reporting in March next year. There is now some indication that that timescale could well slip until later—not after the summer, but later in the spring—so, rather than March, we would be talking about a few months down the line. There may be an issue to do with other events, but I just wanted to let members know that Kerr's report may now be slightly later than we expected. We shall try to establish what the new timetable is.

Kate Maclean: Most of the things that I would want in the draft report have already been mentioned, but I would like to go back to the question that I asked the minister at the end of our evidence session. We must ensure that we are very clear about the funding of any targets relating to the work force, otherwise the whole exercise is purely academic. If we can ensure that that point is covered in the report, I would be happy with that.

Helen Eadie (Dunfermline East) (Lab): I do not disagree with anything that has been said; however, it was a shame that we did not get a chance to ask questions of the ministers on the international comparisons. I would like the report to have a specific focus on comparisons with the Scandinavian systems, which are very similar to ours, as there are examples of good practice there. Denmark and Finland, in particular, leap to mind because they are mentioned in the papers that have been prepared for us, which I warmly welcome. It is a shame that we did not have a chance to expand our questioning and go into the evidence on those comparisons. Given the fact that the research has been done, I hope that that evidence will not be lost.

I think that it was Professor Temple who gave us the evidence about Denmark. He said that an interventionist approach is taken there and that specialists go where the Government states, rather than where consultants dictate according to the market. I hope that it comes out quite strongly in our report that we feel—although I should not pre-empt what other committee members feel—that we would like a more interventionist approach to be taken here, with our saying where the consultants should go rather than their going where they decide that they want to go.

The Convener: Throughout the evidence from the royal colleges and other organisations, I was surprised at how little reference was made to what is happening in other countries. When asked about the European working time directive, they did not know. It seems that there are a great many things of which they are not particularly aware, and that worries me a little. Some of the questioning was about our developing things in isolation from England, but we seem to be developing things in isolation from everywhere else as well. That is a concern, as we are not regularly picking up the best practices and incentives that might exist in places such as

Denmark. Perhaps incentives is not the right word; we are talking about intervention. However, equally, we could be looking at incentives in different countries, but not much work seems to have been done along those lines. I was surprised at that, as I would have expected far more international evidence to have been brought into play in all this.

Mr McNeil: That is important, given the fact that countries throughout the world are experiencing similar problems. This inquiry is about how we, in Scotland, address some of the challenges that we face, and I do not think that anyone is suggesting that there does not need to be a recognition of the drivers that are forcing the change.

The other issue is Professor Kerr's inquiry. We started off with our inquiry; he has shifted the focus slightly, and we need to return to that. Professor Kerr has offered to give evidence. Whether he is going to report earlier or later, given the fact that he is also going to engage communities throughout Scotland and, more important from our perspective, the medical establishment, where he has a great deal of influence, which we will need to get the flexibility to deliver greater access to services, there will come a point when we need to re-engage with him before we make any proposals.

Professor Kerr's written evidence, which was in our papers, says that some of the working groups are going to report in December. A lot of work is under way. We should ask to get access to some of that and see whether we can share some of it with him and get a better understanding of what he is planning in terms of engaging communities and the professions. It might be useful for us to observe some of that. If there are opportunities for Health Committee members to participate in some of that work, that would inform our final conclusions.

The Convener: I think that is right.

Mr Davidson: When we set off on this track, we had no knowledge that there was going to be a Professor Kerr inquiry.

The Convener: That is right.

Mr Davidson: I wonder whether, because of that, we might have to review our final publication date or produce a follow-up report.

The Convener: I would be open to that. I have mentioned once or twice to the clerk the issue of having to hold tightly to the December deadline. Of course, I was advised that the decision was made initially by the committee, but the committee may wish to review that decision in light of Kerr. In the meantime, we will establish exactly how the Kerr review is proceeding, the key dates in respect of what might be available from him, and the opportunities that there might be to re-engage directly with the review. As a committee, we can consider whether in the circumstances we want to re-examine our timetable. Does anyone else wish to come in on this?

Dr Turner: Having taken all the evidence, I am frightened by the fact that no work force plan existed that was robust enough to prevent our getting where we are now. Professor Wildsmith said that we need a needs assessment to know exactly what we provide. I am afraid that services will diminish to the point that we have them only in the big cities. Once services are lost, they are difficult to re-establish. Helen Eadie had the good idea of advising consultants to have outreach services, in order to maintain communities. That is not within the remit of consultants at the moment. I always thought that when consultants had a contract they could be made to work anywhere.

The Convener: We would find it difficult to draw up a report on the basis of looking again at the consultant contracts. We can take a general view on what we consider to be appropriate ways to proceed, but it is for somebody else to examine that.

Mike Rumbles: On the timetable, we knew about the Kerr report when we launched our investigation, and we concluded that, if possible, we would like to complete our investigation by Christmas, and feed in to the decision-making process that Kerr is involved with, because he can use our report as a report of the Scottish Parliament to inform what he is doing. We can always come back to the issue later.

The Convener: Okay.

Mr Davidson: We knew that a report would be called for, but we did not know Kerr's remit. Mike Rumbles might have known something, but the rest of us did not.

The Convener: The position is that a decision was taken that the committee's report be finalised by Christmas. If we as a committee want more time to consider the issues or engage in other parts of the debate, we can make a decision at any stage. None of this is set in stone. I simply remind members that we have a great deal of other work to proceed with, including a major piece of legislation, which will be coming down the tracks shortly.

If everybody is happy, we will close the meeting. We should have a first draft of the report by a fortnight today. We will return to the issue in two weeks' time.

Meeting closed at 16:43.

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