OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 27 September 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

© Parliamentary copyright. Scottish Parliamentary Corporate Body

Information on the Scottish Parliament's copyright policy can be found on the website - www.parliament.scot or by contacting Public Information on 0131 348 5000

Tuesday 27 September 2022

CONTENTS

Col.
INTERESTS.......... 1
DECISION ON TAKING BUSINESS IN PRIVATE 2
WINTER PLANNING 3
SUBORDINATE LEGISLATION.......... 65
Food Information (Transitional Provisions) (Miscellaneous Amendments) (Scotland) Regulations 2022 (SSI 2022/265) 65
Sports Grounds and Sporting Events (Designation) (Scotland) Amendment (No 2) Order 2022 (SSI 2022/263) 65

HEALTH, SOCIAL CARE AND SPORT COMMITTEE

27th Meeting 2022, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

*Paul O'Kane (West Scotland) (Lab)

COMMITTEE MEMBERS

*Stephanie Callaghan (Uddingston and Bellshill) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
Evelyn Tweed (Stirling) (SNP)
*Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jeff Ace (NHS Dumfries and Galloway)
Dr Jennifer Armstrong (NHS Greater Glasgow and Clyde)
Donna Bell (Scottish Government)
John Burns (Scottish Government)
Dr Adam Coldwells (NHS Grampian)
James Dornan (Glasgow Cathcart) (SNP) (Committee Substitute)
Caroline Lamb (Scottish Government)
Alex McMahon (Scottish Government)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 27 September 2022

[The Convener opened the meeting at 09:01]

Interests

The Convener (Gillian Martin): I welcome everyone to the 27th meeting in 2022 of the Health, Social Care and Sport Committee. I have received apologies from Evelyn Tweed, and James Dornan is attending online as her substitute. I invite him to declare any interests that are relevant to the committee's remit.

James Dornan (Glasgow Cathcart) (SNP): I have no interests to declare, but I ask members to look at my entry in the register of members' interests.

The Convener: Thank you.

Decision on Taking Business in Private

09:01

The Convener: Under our next agenda item, do we agree to take items 5 and 6 in private?

Members *indicated agreement.*

Winter Planning

09:02

The Convener: Our next item is two evidence sessions on winter planning. In the first session, we will focus on the national health service and social care in Scotland. I welcome Caroline Lamb, chief executive of NHS Scotland and director general for health and social care; Donna Bell, director for social care and national care service development; Alex McMahon, the Scottish Government's chief nursing officer; and John Burns, chief operating officer at NHS Scotland. Good morning, all, and thank you for coming in person—what a treat it is to have a whole panel in person.

Winter planning will be a big focus. I ask Caroline Lamb to give an overview of the challenges this winter and how you are preparing for them.

Caroline Lamb (Scottish Government): I am grateful for the opportunity to be here, particularly in person, to update the committee on the actions that we are taking to support our health and social care services this winter. I appreciate the committee's support in rescheduling the date of this session following the passing of Her late Majesty Queen Elizabeth II.

There is no doubt that we face an extremely challenging period this winter. As we went into last winter, we were hit by a new Covid wave, which was driven by the omicron variant, with Covid bed occupancy peaking at 1,600 in January 2022. Only weeks after that, in April, there was a resurgence of the virus, and the number of Covid hospitalisations rose to 2,400—the highest level to have been recorded throughout the pandemic. Slowly, that pressure fell to about 600, only to rise again and peak in July at 1,800.

I set out that detail to remind us all of the context in which we are still operating. Our health and social care systems have barely had a chance to draw breath between Covid waves. Even now, as we approach winter, our Covid occupancy still sits at about 600—it was 629 on 18 September. It is therefore clear that Covid is still very much with us and very much contributing to the pressures that we face.

Surveillance and modelling remain critically important to us. We continue to work with Public Health Scotland, which will shortly publish its national respiratory surveillance plan, supported by up to £7.5 million of funding.

Vaccination remains our best line of defence, so our health and care system is rolling out vaccination programmes for flu and Covid. They build on our existing vaccination programme, which has delivered more than 12.6 million Covid vaccinations since the start of the pandemic. Covid boosters are now being offered to priority groups, and everyone who is eligible can safely receive that vaccination and the flu vaccination at the same appointment.

Not only will this winter be difficult for people across the country but it will present extra challenges for our staff and colleagues who work across health and social care. As well as the increased number of patients that winter weather brings, the country will be continuing to face the challenges of the on-going and escalating cost crisis. That adds further pressures to our NHS and social care systems, which are already dealing with very high levels of continuing pressure and demand.

When the First Minister recently set out the programme for government, she emphasised the importance of the NHS recovery plan for rebuilding our health and social care services. That five-year plan, which was published in August 2021, sets out the course that we are taking to drive additional capacity, improvement and innovation to support recovery. It is backed by more than £1 billion of funding and it supports in-patient, day-case and out-patient activity, as well as the implementation of sustainable improvements and new models of care. It sets out investment in a network of national treatment centres to increase capacity for diagnostics, general surgery, orthopaedics and ophthalmology. On 4 October, the Cabinet Secretary for Health and Social Care is due to update Parliament and set out the progress that we have made against the NHS recovery plan, as well as our winter resilience plan.

Just last week, the United Kingdom Government announced its plan for patients and outlined changes to taxation in the fiscal event. Work is on-going to assess those plans and to understand the impact of those measures. Committee members will be aware that the Deputy First Minister promised to undertake an emergency budget review within two weeks of last Friday's UK Government fiscal event. That review will set out the next steps that we will take as we manage our budgets across the Government and within health and social care.

As we approach winter, we are fully aware of the difficult circumstances that front-line staff face. Therefore, as an inherent and important part of our planning for winter, we have been working hard—and we will continue to do so—to support staff and grow our workforce.

We know that such pressures are apparent not just in the NHS but in social care. We continue to see difficulties in the social care system, with

pressures in relation to providing people with the levels of care and support that they need to go home from hospital. That has been exacerbated by increases in staff absences, as well as long-standing recruitment and retention issues.

It is important to remember that social care is local government's responsibility, but we have announced additional support to address delays by increasing capacity for care at home, increasing the hourly rate of pay for care workers, supporting interim care arrangements and enhancing multidisciplinary teams. We have also introduced in Parliament legislation for the national care service, which will put in place long-term reform to protect and improve social care as a profession and an essential service.

We have been working on ways to continue to supplement the NHS workforce. Last month, working at pace and in partnership with unions and employers, we published new national guidance for retiring NHS staff to return and support the service. We also continue to support international recruitment, the increase in multidisciplinary teams to support primary care, and additional healthcare support workers.

We know how essential our health and social care staff are. Throughout the pandemic, they have shown extraordinary commitment and worked under pressure to support people. Their wellbeing remains our key priority, and we are determined to offer them fair pay deals in what is a very challenging financial environment.

Committee members will know that we have made a 5 per cent pay offer to NHS agenda for change staff, which is the most significant single-year uplift in the past two decades. Although we are disappointed that that offer has been rejected, we remain committed to negotiating a settlement that will avoid industrial action.

The health and social care system is not immune from the rest of the challenges that society faces. Hospitals, clinics and social care settings will all face increased energy costs. We are investing more than £73 billion in health and social care over the resource spending review period, and a further £1.3 billion in capital funding through to 2025-26, to support recovery.

We have put in place the NHS climate emergency and sustainability strategy to support boards to implement energy efficiency measures and generate on-site renewable electricity. We are investing at least £200 million in our green public sector estate decarbonisation scheme to reduce emissions and energy costs across the public sector.

Nonetheless, the challenges that health boards face are real, and we will continue to work with them on the financial pressures across the system. The plans that the cabinet secretary will publish and announce to the Parliament on 4 October will set out more information on that. I thank again our incredible health and social care staff, who have made an incredible contribution to keeping us safe through the pandemic and continue to do so in this period of recovery.

With my colleagues, I am happy to take questions on those matters or any others that you would like to ask about.

The Convener: Everything that you said in response to my question contained detail that my colleagues will want to delve into a bit more deeply. I have no further questions just now and I hand over to Tess White.

Tess White (North East Scotland) (Con): I, too, support and say thank you to the exceptional staff who work in the NHS and social care. Ms Lamb, are you nervous that the NHS will not be able to cope this winter?

Caroline Lamb: It would be foolish to be complacent as we go into a difficult winter, but we have been planning intensively with our NHS boards. That is not new. We work alongside our boards, in partnership, throughout the year. We engage with them on their remobilisation and annual operating plans. They all have in place plans to deal with surge capacity when required.

We know that our NHS has had a strong track record in the past two years of responding to unprecedented demand and pressures in the system. However, we cannot be complacent, so we continue to focus on additional measures. The vaccination programme is critical. It is our first line of defence against pressures that new waves of the Covid pandemic cause. That is not only about limiting hospital admissions—although we clearly do not want people to get ill with Covid—but about reducing the number of days that we lose through staff being unable to work because they are impacted by Covid.

The vaccination programme is key. It is great to see strong uptake among the most elderly and most vulnerable parts of our population and really strong uptake in care homes. We will continue to move through that programme. As I said, we are also focused on what we can do to improve capacity and reduce occupancy levels in our hospitals as we head into winter. I am happy to go into more detail on that.

We are asking where we can make interventions that will support increases in the workforce. A lot of that work is under way. I can come back to you with details about the precise measures that we have put in place and where we have got to on some of that.

We are improving capacity, continuing to support our workforce, considering new and innovative ways of providing treatment and going out and about to talk to staff a lot so that we understand what the pressures are like on the ground, as well as seeing them in the numbers.

Sandesh Gulhane (Glasgow) (Con): It is important to say to anyone who is watching that, if you are eligible to get a vaccine, please, please go and get one, because it will save your life.

I thank the witnesses for coming to see us. I listened to what Ms Lamb said with a lot of interest and I will pick up on Tess White's question. You said that £7.5 million had been spent on modelling. You have not talked about anything specific that is being done to improve what will happen. Are you confident that the NHS will cope this winter, based on the modelling that you have spent £7.5 million on and all the work that you have been doing? Will you tell us about the things that you have done under the strategies?

Caroline Lamb: I clarify that the £7.5 million that we are investing in Public Health Scotland concerns the work that it is doing on supporting modelling of future waves of Covid and on surveillance, so that we are in a position to identify new variants of Covid and act on that information. That is a tiny element of the work that we have been doing.

It might help if I talk a bit about work that we have been doing on the workforce; then I will pass to colleagues to talk about work that we have been doing to increase capacity in and flow through our hospitals.

09:15

We have confidence in our NHS. We have a strong service. We are not underestimating the challenge as we go into winter, but we are working across the system to do everything that we can to support addressing that.

There has been an increase of more than 28,100 whole-time equivalents in the workforce since 2006. I appreciate that that is a long time; I will go back and focus on the time before the pandemic.

Since December 2013, our workforce has increased by 8.9 per cent. That is on top of the increase in general practitioner numbers, which are up by 3 per cent since September 2019, and the increase in people in multidisciplinary teams, who support general practice—their numbers went up from 1,683 in 2020 to 2,427 in 2021 and are now sitting at more than 3,200. Those multidisciplinary teams are critical to supporting, and giving us more capacity in, primary care—they support GPs and improve direct access to physiotherapists, for example, for people with musculoskeletal problems.

Over and above that, we increased the number of healthcare support workers by more than 1,000 last year. Those people are in the system and are contributing. We have supported the Scottish Ambulance Service to increase its staff by 540 last year and by an additional 574 this year. I can say more about the workforce, in terms of training numbers, but I will pause there.

The Convener: Some of my colleagues will ask questions specifically on the workforce. That is a good springboard for that conversation later in the session.

Caroline Lamb: I do not want to pre-empt those questions. I will pass to John Burns to say a bit more about our work on unscheduled and urgent care and on improving capacity and flow across the system.

John Burns (Scottish Government): I highlight four things that we have been working on with our colleagues across the health and care system. The first is continuing to take forward the right care, right place initiative, to ensure that we are giving citizens the best advice and clear information about where best to access their healthcare.

We are building on the redesign of urgent care work, which started about two years ago. Central to that is flow navigation, which supports patients by directing them to the right professional or the right location.

Within that, it is important to flag the good work that the Scottish Ambulance Service has been doing under its see-and-treat initiative to attend and treat individuals at their home or at the point of an incident, rather than conveying them to hospital. There have been significant improvements in that area, which we want to continue to support. In addition, NHS 24 has high success rates in working to complete patient care at the first point of contact.

The second area is the work that we have been doing to increase capacity out of hospital—often, that is called virtual capacity. Our focus in that has been on hospital at home; out-patient parenteral antimicrobial therapy; community respiratory teams; and the Covid remote health monitoring pathway, which we introduced last winter. Across the country, those services have grown and have done so with strong support from our clinical teams. We are utilising probably the equivalent of the bed days of a large district general hospital through those pathways of care. We will continue to build and develop that. As we have been out around the country, we have seen the benefits of that and the benefits that local teams have described for the care of individuals.

The third area is working with our health and social care partnerships and building on the strength of integration across our health and care systems. There are two areas of focus in relation to that. One is really building and maximising the opportunity that the new MDTs give us and the skills that we have in the community to support patients in the community and avoid a hospital attendance or admission. Our other focus is on working to improve the position on delayed discharges, which impact on hospital bed capacity.

The final area is the urgent and unscheduled care collaborative, which we launched on 2 June. It provides an opportunity to bring together the redesign of urgent care with other impactful and high-impact changes and to work with health and care systems across the country to look at the areas that would provide greatest impact for them. In that programme, we are building on work around the redesign of urgent care, but we are also looking at initiatives such as discharge without delay, so that we can reduce any unnecessary delay in discharge, and bringing discharge forward in the day, which we know can improve flow through hospitals.

Those are the four principal areas that I would draw out in relation to our discussions on capacity.

The Convener: With that in mind, I will hand over to Emma Harper, who has questions on accident and emergency services.

Emma Harper (South Scotland) (SNP): Good morning, everybody. A and E discharges and the four-hour waiting time target are all over the news all the time. I know that looking at what causes those breaches in the four-hour target, and the on-going issue about delayed discharges or the whole throughput, is complicated.

John Burns just described what actions are being taken. I am interested to hear about what specifically causes the delays in A and E treatment—what causes that four-hour target to be breached? It is not the case that people are just sitting on a trolley waiting for somebody to see them; they are still getting some care at that time, whether it is blood pressure assessment, vital signs or waiting for an X-ray or whatever. It is not that people are just sitting there doing nothing. I am interested in what causes the delays and what further specific action we can take to reduce them.

Caroline Lamb: I thank Emma Harper for highlighting that it is not simply about people sitting waiting to be seen. A lot of the long delays relate to people who are, in fact, being cared for, and who are quite often in beds rather than on trolleys. Nonetheless, we are working really hard with colleagues to improve the situation.

On the work that we have been doing to identify exactly what causes those delays, a number of factors revolve around flow through the hospital and occupancy levels in hospital, as well as length of stay. I will ask John Burns to say a bit more about the detail of some of those elements.

John Burns: I absolutely agree with the point that people are being treated; they are receiving treatment while they are in A and E.

I also acknowledge the incredible work that our teams are doing right across the health and care system, and in our accident and emergency departments. I often describe the A and E measure as a barometer measure, because it is a measure of how the system is working.

On pathways in and out of A and E, clearly, we want to maximise the number of patients who we can discharge directly from A and E and to admit only those who need a hospital stay. There is a number of flows into the A and E department. Where patients are waiting for unacceptably long periods of time, it is because of the flow into a hospital bed. That is why we are focusing on a number of areas. Delayed discharge is one area of our focus on improvement, but there is also discharge without delay.

It is important that we are able to properly discharge people in the morning so that we can maintain and manage flow through the hospital throughout the day, not just at a single point in time, so we want to improve our work in relation to discharge.

We are also looking at maximising opportunities for senior decision makers in A and E, because, again, we know that that can support a decision to discharge rather than admit, for example. Having that focus on assessing to admit rather than admitting to assess is very important.

Emma Harper: Last week, we had a chamber debate about out-of-hours GP services and I quoted some percentages in relation to out-of-hours care reducing the number of hospital admissions, so that approach has been quite successful. I know that there are challenges around staffing out-of-hours services in some places in Scotland, but those have been a good way of reducing hospital admissions. Is that correct?

Caroline Lamb: Yes, that is correct. We need to think about all the aspects of out-of-hours services, encompassing the work that John Burns has already referenced around what the ambulance service is doing, as well as the work that NHS 24 is doing in terms of managing to deal with somebody’s issue on the telephone rather than them needing to phone back or turn up at A and E.

John Burns: Out-of-hours is incredibly important as part of our wider urgent care

provision. As we have developed the redesign of urgent care and moved forward with flow navigation, that has supported out-of-hours. However, it is also important to recognise the multidisciplinary skills that we have in that out-of-hours urgent care team. Those skills afford us the opportunity to support individuals differently. That strength has come from developing those multidisciplinary teams over recent years.

Emma Harper: I have a final question. Ahead of getting into winter, do you feel that we will be able to reduce the numbers or the waiting times from the current data? Are you optimistic about the winter ahead?

Caroline Lamb: As I said earlier, I would not be complacent about the challenges that face us. However, we are working very hard with our colleagues in the NHS and in the HSCPs to improve that flow and, therefore, to start to see an improvement in the published statistics.

We should also remember that we still have the best performance in A and E in the UK.

Tess White: I have a question for Alex McMahon. NHS Forth Valley has been very much in the spotlight, sadly, because of shocking A and E statistics. However, yesterday, it emerged that A and E departments were at overcapacity in every single hour of every single day in August. We are about to enter winter—it is serious that there is a massive issue. What are your thoughts on levers that can be pulled to help?

Alex McMahon (Scottish Government): I will pick up on some of Caroline Lamb's points in relation to the workforce.

Caroline mentioned the retire and return policy—that is a once for Scotland policy, which was published four weeks ago. It came on the back of the cabinet secretary hearing from staff directly about what improvements would be necessary for them to want to continue working within the NHS once they retire. Normally, people would register in the staff bank and they might pick up shifts here and there. However, people were saying that they would like 10 hours or 15 hours to be guaranteed at hospital Y or ward B, for example. This policy enables us to offer those options to retirees. We are hoping that the policy will yield quite a benefit for people who are retiring from September onwards; we will track that with health boards.

Caroline also mentioned the work that we are doing around international recruitment. We are looking to recruit internationally—not just nurses but allied health professionals and midwives. We have started that process and we already have circa 250 people in NHS Scotland as part of that work.

We are also doing a significant piece of work on developing a care framework for bands 2 to 4, which represent the unregistered workforce. It considers whether, in the band 4 level in particular, registered nurses and others could be freed up to carry out the more direct clinical care for which they are qualified.

09:30

We also intend to carry out work on final-year students being placed where there are vacancies on boards, so that they get ready to take up posts immediately. They receive training prior to their registration coming through, so they are match fit, as it were, to be registrants at the point of their registration coming into force.

We are doing another piece of work that is similar to one that is being carried out in NHS England, which aims to consider the position of reservists and how we could pull in people who might have retired some time ago. Equally, the new Secretary of State for Health and Social Care has agreed that the UK Government will keep the emergency register open, so that people who wish to remain on it can do so for another two years. All those measures are part of what we are doing on nursing, and on the AHP workforce, in particular.

Tess White: That is very helpful.

The Convener: I will bring in James Dornan.

James Dornan: As someone who, unfortunately, has been a user of the health service quite a lot over the past 12 months—and continues to be—I will start by saying what a great service it still is. In every single department that I have had to attend, the care and attention shown to me have been just incredible. Also, as Emma Harper said earlier, when someone is waiting in accident and emergency, most people are getting some kind of attention.

I want to discuss this issue. We have talked about targets, and we are focusing on this winter. In the emergency situations that we have gone through over the past couple of years and that—who knows?—we might face again this winter, do targets help or hinder? I understand why they were brought in, and sometimes it is great to be able to say that we are the best in the UK. However, looking at the situation from outside, I sometimes feel that it focuses attention on the wrong thing: rather than being about the people who are getting treatment, it is about those who have not been able to get it because of the pandemic or for other reasons.

The Convener: I put that question to Caroline Lamb.

Caroline Lamb: It is good to hear your personal reflections on your experience of the NHS. I

certainly echo your views on the care, compassion and commitment that I see from staff when I am out and about in the system and talking to people, and also the levels of satisfaction that we still see with the service that people get across that system.

On your question about targets, inevitably, over the period since the Covid pandemic, we have had to respond flexibly and be really clear about the priorities that we were setting for our health and social care system. As you will be aware, in the early stages of the pandemic that meant stepping down a lot of planned care, and we are still working very hard to recover from that position.

Initially, we issued a clinical prioritisation framework in response to moving back to more normal lengths of wait. We have worked with boards to relax that over the past couple of months, to try to get the balance right between dealing with people whose condition is urgent and important and with those who have been waiting a long time. As you will know, at the beginning of July, the Cabinet Secretary for Health and Social Care announced targets for ensuring that we get through those long waits. As we have made such changes, we have worked closely with colleagues on boards, who absolutely understand the need to balance the different aspects of how we are able to operate the system in order to ensure that we are able to give people good-quality care.

John Burns described the A and E standard as a barometer. Although we recognise the challenges in meeting that target at the moment—because the pressure is across the whole of the system; it is not just about what happens in A and E departments—I do not hear voices in the system suggesting that we should step back from that, because it is seen as being an important measure of how quickly we are able to respond to and treat patients.

I ask Alex McMahon, who is the clinician among us, whether he wants to add anything.

Alex McMahon: As Caroline Lamb said, there is value in having a target, but it must be proportionate. As she said, any clinician would probably say that the A and E target is helpful, because it is about patient safety and ensuring that people are seen and treated as quickly as possible. We all want performance on that to improve, but the point has been made that people are still being seen—their treatment might start, but they have to spend more time in the ED until we move them through the system. People are doing everything that they should to ensure that patients are safe. It is right to ask the question, but the fundamental point is that that target is about patient safety and quality of care.

The Convener: I will bring in Paul O’Kane, to be followed by David Torrance.

I think that Paul’s connection might have frozen, so I will come back to him.

Paul O’Kane (West Scotland) (Lab): I appreciate what colleagues are saying about their anecdotal—[*Inaudible*.]

The Convener: I am sorry, Paul—try to ask your question and we will see whether we have still got you.

Paul O’Kane: Can you hear me? Thanks, convener.

I understand what colleagues have said about their anecdotal experience in the NHS and the comments that have been made about staff, but John-Paul Loughrey, who is vice-chair of the Royal College of Emergency Medicine Scotland, has said that frail elderly people are being left on trolleys for hours because of shortages and that the initiatives that the Government has taken—to move people with minor ailments away from A and E, for example—are not delivering the change that is needed. He has said that every hospital in Scotland is “under the cosh”. What is the panel’s view on those comments? What interaction has there been with the RCEM?

The Convener: I do not know whether Alex McMahon wants to respond.

Alex McMahon: I cannot comment particularly on dialogue with the Royal College of Emergency Medicine. On the principle of using trolleys, we recognise that people sometimes wait too long, but everything is done to ensure that people are safe while they are in the ED on a trolley. It is not the case that people are not being supported and looked after. Staff ensure that the right level of care is provided—patients are just not in the right place. Every effort is made to move people to the right place as quickly as possible.

David Torrance (Kirkcaldy) (SNP): Good morning, panel. Last week, record numbers turned up every day at Victoria hospital’s A and E. Some people see A and E as an easy pathway when they cannot get other services in the area. How can we quickly assess people and get them to minor ailment services, community pharmacies or whatever is in the area? That would take the pressure off A and E.

Caroline Lamb: That is a good question that sits at the core of a lot of the work that we have been doing on improvements to urgent and unscheduled care. John Burns talked about people being seen at the right time and—critically—in the right place.

There are lots of other pathways through NHS 24; through pharmacy, which you mentioned;

through the investment that we are making in extending the multidisciplinary teams that support our primary care colleagues; and through minor injuries units. John, do you want to say more?

John Burns: Supporting citizens to make the right decisions for them about where they receive care is important. We have had strong communication messages under the right care, right place initiative—we have leafleted and done a range of things—and NHS Inform is a good resource for supporting individuals.

We need to keep strengthening our messages and supporting citizens. I come back to the redesign of urgent care. Through that, we introduced planned attendances for minor illness or minor injury. Subject to their condition, an individual can attend at a time that suits them, rather than just turning up at an A and E department. More and more people are taking the offer of a planned appointment, and the anecdotal evidence is that people find that helpful because they can fit it around their other responsibilities. We will continue to develop that so that we manage the flow into our A and E departments as effectively as we can.

It is also important to recognise that the minor injuries flow is separate from the flow for critical and life-threatening conditions care. We have a clear understanding of, and services to support, minor injuries and minor ailments, but the messaging continues to be important.

The Convener: We move on to waiting times and cancelled operations, which Caroline Lamb has already referred to.

Gillian Mackay (Central Scotland) (Green): During the pandemic's most acute period, the public received a large amount of information about services and what their care would look like, and many people very much valued that. Many will understand why operations have to be postponed, but some constituents feel that information is lacking on next steps and what other support is available while they wait for a new operation date.

What work is being done to ensure that patients have information on how to keep themselves well and get support while waiting for an operation or, indeed, when an operation is cancelled? I direct that question to Caroline Lamb.

Caroline Lamb: I am happy to kick off on that and I will hand over to John Burns to give you some detail.

We understand that people are waiting longer than we would ideally want them to. We are still prioritising the most urgent cases, and the cabinet secretary has announced a target to get through and deal with those who have been waiting the longest. That said, we understand that that still means that people are waiting, perhaps in pain or discomfort, so we are really keen to ensure that they have the best information on the likely waiting times. We have recently started to make that information publicly available through Public Health Scotland. However, we are also very focused on supporting people to wait well and to understand the support that is available to them in communities.

John Burns: The wait well approach is incredibly important and it is an area of preventative and proactive care that we are focused on. We are also improving our communication with patients with regard to the initial letters that they receive, pointing them to the new information on waits and, importantly, giving them a point of contact if they have concerns or they feel that their condition is deteriorating. Those aspects are important in supporting patients on waiting lists.

Sandesh Gulhane: In answer to an earlier question, you talked about the increase in workforce, but the British Medical Association has said that consultant vacancies are now at 15 per cent and that there are 6,000 nursing vacancies. We have talked about the right care, right place guidance, but I note that the community pharmacies that David Torrance asked about choose to close for a half-day on Saturdays so that they can move staff to another pharmacy and get paid double.

We have also mentioned out-of-hospital capacity, but I note that OPAT was being used at Raigmore hospital in 2015. You talked about the strength of integration with regard to delayed discharge, but we have actually had a decrease in bed numbers and a record number of people who are ready to go being delayed in hospital. Moreover, staff and patients do not really like the redesign of urgent care.

I just want to look at what you say has happened and the problems that we are seeing now. For example, the cancer statistics that have just come out show that only 76.3 per cent of patients are being seen within the target. That figure is the worst on record, and it is a priority area. How are we going to address and fix the situation?

Caroline Lamb: Starting with the level of vacancies, I have to point out that any big system that employs as many staff as NHS Scotland does will always have turnover and a certain level of vacancies. The vacancy rate will also be impacted by the fact that we are increasing the establishment in certain areas. By that, I mean that we are looking to recruit more staff, particularly with our national treatment centres coming on stream and the new treatment centres

in Fife, in Highland and at the Golden Jubilee hospital over the period.

As for the BMA's comments, which you referred to, our pipeline for filling consultant vacancies is absolutely dependent on the number of doctor trainees going through the system. One of our good news stories in 2022 is that the fill rate for junior doctor training posts is the highest in five years. The posts are 95 per cent full, with 100 per cent of GP posts filled in the first round.

I am sure that colleagues understand this, but I make it absolutely clear that those are doctors in training who are in clinical placements. In other words, they are not yet fully qualified consultants, but they are all providing critical services to patients as they go through their training programmes. That healthy pipeline is, as I said, a good news story, and it enables us not only to support consultants by having juniors in place, but to fill consultant posts in the future.

09:45

I have already talked about the multidisciplinary teams, who are critical in supporting our general practitioners to be generalist experts in their communities. They are still a relatively new development but, as I said, they have increased by 91 per cent—they have almost doubled—since March 2020. You will have seen that, in its paper "Our plan for patients", the UK Government talks about extending the number of practitioners who work alongside GPs. We already have more than 3,200 staff working in that capacity.

As for the impact that the approach is starting to have, some work that has been done in Lothian indicates that one physiotherapist in a GP practice effectively frees up two and a half days—or five sessions—of GP time, which obviously increases not only the GP's capacity but access to consultations for patients. In Forth Valley, the involvement of physios has led to a reduction of about 9 per cent in referral rates for musculoskeletal conditions. Lots and lots of good stuff is happening across our systems.

On delayed discharge, I am conscious that Donna Bell has not had a chance to say very much, so I might hand over to her to say a little about our work in that respect.

The Convener: A couple of colleagues want to ask about delayed discharge in a more focused and in-depth way, but I am happy to bring in Donna Bell to give an overview. After she does so, I have a question that I would like to ask.

Donna Bell (Scottish Government): We have been working really closely with the Convention of Scottish Local Authorities and the Society of Local Authority Chief Executives and Senior Managers on social care issues, both throughout the pandemic and into this summer in preparation for winter. We meet regularly—a minimum of once a fortnight, but usually more often than that—and the cabinet secretary and ministers also have very regular meetings with local partnerships, which include NHS chief executives, local authority chief executives and health and social care partnership chief officers. Communications are therefore very strong in that partnership sense.

Last October, the cabinet secretary announced £300 million of funding, which equates to £20 million in this financial year, for step-down or interim care, including home beds; £124 million for improving capacity and care at home and considering other options such as technology; £40 million for multidisciplinary teams; and £200 million to increase the rate of pay for social care staff to £10.50 per hour.

As I said, we are working closely with partners, and we are seeing some impact from the investment that has been made. For example, the returns that we have from 24 partnerships show that, in the most recent quarter, more than 300 people have been discharged to interim care home beds; more than 2,000 community alarms are now in place; around 30,000 items of community equipment have been provided to people; and around 400 full-time equivalent internal front-line staff have been recruited.

We are starting to see some traction from the investment that has been made, and we certainly know that our partners in the field are working very hard in a joined-up way. John Burns talked about the need for a whole-system approach to the issues. After all, the flow does not stop at the hospital door; instead, it needs to go out into the community.

The pressure on the social care system is very significant, in the same way as it is for the NHS. The bulk of the people who are waiting for care are in the community. I do not have today's figures but, usually, more than 90 per cent of people who are waiting for assessment or care are waiting in the community. We must ensure that we do not lose focus on those people, given their need for care and the need to have that care in the right place, and that we think about their health and wellbeing in the broadest possible terms.

We must also consider the potential impact on public services more broadly. If people are not supported in their own homes, they are more likely to be admitted to hospital, which creates that cycle.

The overview is therefore that the system is under significant pressure and that lots of staff and providers are working extremely hard, in partnership, to address those pressures.

The Convener: I will bring the discussion back—

Sandesh Gulhane: Convener—

The Convener: Sandesh, the theme of these questions is waiting times and cancelled operations so, if you do not mind, I will ask a question on that. If I have time, I will come back to you, but lots of people want to ask questions and we still have lots of themes to get through. Thank you.

I want to bring the discussion back to the subject of avoiding cancelled operations. You mentioned the backlog that is a result of the pandemic, and you have referenced some of the things that you are trying to do to address it. I am happy to hear more about that, but how do you plan to avoid cancellations of a non-clinical nature? Covid is still out there, and there are staff absences. I am thinking of any pressures that might cause cancellations this winter. What are you doing to avoid those?

Caroline Lamb: You are quite right that the number 1 cause of cancellations has been Covid, whether they were due to the pressures that Covid introduced to hospitals, which required them to switch capacity to treating patients with Covid, or due to staff absences because people have been unable to go to work when they or their families have been impacted by Covid. We are therefore keen to look at how we can protect sites from Covid.

The Golden Jubilee hospital has been invaluable because it has been kept as a green site, which allows us to push through planned procedures. That is also fundamental to our work to develop the national treatment centres because we have a clear separation and are able to keep working through the waiting list for planned procedures.

Some of the work that we have just touched on with regard to moving some of that capacity out of the hospital is also fundamental to that process. We are getting to the point where we are able to deal with much more in the community. John Burns talked about some of the hospital at home work as well as some of the remote monitoring work. The final thing that I will mention—I will hand over to John to provide some of the detail—is the work that the centre for sustainable delivery is leading on innovations and improvements that release appointments for out-patients for diagnostics and other aspects that are critical to planned care.

John Burns: We know that it will be a difficult winter, but we are clear that we need to do all that we can to protect planned care. That includes maximising virtual capacity and optimising day surgery and 23-hour surgery. When I have been out speaking to colleagues and boards, I have seen good examples where they have been able to use their day surgery facilities to maximise the surgical procedures that they can offer, and the 23-hour surgery has added to that.

As Caroline Lamb said, we need to maximise facilities such as the Golden Jubilee hospital and ensure that we use those theatres and facilities to best effect. We should also recognise the importance of collaborative working across boards. We have been encouraging that and we have seen some early impacts where boards are working together to support care by either moving a consultant team or moving patients to get the treatment. That has added capacity and support.

The centre for sustainable delivery and working differently are important parts of that, as is the ability to use new technologies and to work with clinical teams to change the way that we work. Patient-initiated review is an example of that. Finally, we are seeing new roles to support elective care that are not always the traditional consultant or medical ones. That also creates resilience in some parts of our service.

The Convener: I think that Sandesh Gulhane wanted to ask about cancer treatment waiting times in particular.

Sandesh Gulhane: My question was about the new cancer statistic of 76.3 per cent, which is the worst on record. Obviously, that is a priority area, so what are you doing to ensure that we get that figure up?

Caroline Lamb: My apologies—I realise that I did not cover that point in my answer.

We have consistently met the 31-day standard, but we have been struggling and have been challenged by the 62-day standard. We have invested £10 million in additional diagnostics. We currently have six mobile magnetic resonance imaging units and five mobile computerised tomography scanners, which are helping to increase our capacity for early diagnosis. We are also investing £44 million in our detect cancer early programmes.

We are looking to try to understand where we are challenged within the data. We have seen a significant increase in the number of referrals for urgent suspicion of cancer. There is more work on-going to look at that. That is absolutely a focus of our attention.

The Convener: I want to bring in James Dornan before we move on to talk about bed numbers.

James Dornan: I want to go back to something that Sandesh Gulhane said, which concerns me greatly. He said that pharmacy staff close on Saturdays at lunchtime, so that the staff can go and work at double time elsewhere. If that is a

fact, it is shameful that pharmacies behave in such a way. If it is not a fact, it is shameful that that accusation has been made in a public committee such as this one. Can we clarify whether there is anything to back up that statement?

The Convener: Do any panel members have any comment to make on that, or do they know where we can find out about that?

Caroline Lamb: We would be happy to take that away and respond in writing to the committee.

The Convener: Okay. Thank you. Can we move on to talk about bed numbers?

Carol Mochan (South Scotland) (Lab): I want to be clear that I accept that the panel members want things to work and that they are working hard to get this in. However, I want to talk a wee bit about the reality that we observe and what we see in our in-boxes from patients who have waited on trolleys and have found that the staff work 100 per cent and above and beyond, but are still finding it difficult. Staff trade unions also tell us how much stress staff are under in relation to beds. The professional organisations tell us that, too.

I visited a local hospital at 9 o'clock on a Friday morning. There were three ambulances waiting to unload, every accident and emergency bay had had a patient in it for more than 24 hours, and the bed capacity was basically non-existent. I was told by staff and managers—everybody—that that situation was not unusual.

We need to be realistic about where we are, and we need to talk about whether there is enough support from the Government to help health boards. Will we have enough bed space this winter? The issue is not just bed space: I have been advised that the ratio of bed space to staffing is not at the level that we need even before we fill the beds—they are constantly getting staff in again and again.

I appreciate that you want things to work, but how realistic is it that things will be in a good space this winter?

Caroline Lamb: As I have said, we do not underestimate the challenges going into the winter. We are heading into the winter with our hospitals running at higher occupancy levels than we would ideally like, and our efforts to support boards to manage that are based on trying to ensure that people are in hospital only if they really need to be. That is about the work that is done at the front door on whether people can be treated by the Scottish Ambulance Service in their own homes, whether there is an option for people to see a multidisciplinary team member who supports a GP practice, and whether people can get an organised appointment for a minor injury through NHS 24. All those measures serve to keep people away from the front door.

10:00

As Donna Bell said, we need to make sure that, when people are fit to be discharged from hospital—nobody wants to be in hospital for any longer than they absolutely need to be, and John Burns has talked about discharge without delay—we are able to get them through the hospital system quickly and into the social care system, where they can be looked after in their own homes or in a homely setting, because that is far better for people and is, I am sure, what we would all want for ourselves.

We are also focused on increasing our capacity for people in their own beds. Work is being done around hospital at home and remote monitoring. That is about how we can take services to people. We have seen some brilliant examples of that in our remote and rural communities, which are transferable to the central belt.

We also need to be clear that the current situation is putting a huge amount of pressure on staff. Believe me, we all understand that. I am out regularly in emergency departments, I talk to staff, and I really do understand the pressures that they are under.

There was a question earlier about trying to support the public to make the right decisions about where they go for care. That is important, as we all have a responsibility to try to help our system.

The final point was about the staff-to-beds ratio. I will invite Alex McMahon to say something about the work that we are doing on that. We have talked a lot about the work that we are doing to try to increase staffing, but how we match staffing to the acuity of patients is also an issue.

Alex McMahon: I will pick up on that thread. Scotland has a higher ratio for the number of nurses per thousand beds than the rest of the UK has. That is a good baseline to start with but, as has been said, we cannot be complacent.

I have already referenced a number of things that we are doing. We are also going to commence a big piece of work on agency supplementary staff spend. Within that, we are going to work with a stay local, work local principle, rather than staff having to travel around different parts of the country. Staying local means that people will know their hospital, their wards and their patients. That is hugely beneficial, and it will ensure that staff are not necessarily out of pocket.

We are about to commence a piece of work that considers what we can do around the agenda for

change terms and conditions that would allow us to achieve that outcome for patients and staff. We are also implementing the Health and Care (Staffing) Scotland Act 2019, as work on that was paused in 2019. The act will be fully implemented by April 2024. We are working with boards to test out the tools that indicate what ratio of staff to patients we need. The important point is that that is not just about nursing; it is multidisciplinary. We need to think about AHPs, physios, occupational therapists and other staff in and around that complement so that we can get the right complement of staff and do not look at the issue in a uni-professional way.

To go back to the previous questions about how we are ensuring that we are sustaining services as we go into winter, the vaccination of staff is hugely important. Staff should get vaccinated, just as their patients and residents should. We are working continuously to look at the evidence on infection prevention and control measures to ensure that we are keeping people safe from infection while they are in hospital and, where we can, we flex that to allow patients and staff to move around hospitals safely. We are also doing work on staff testing.

There is a lot of activity in that space, and we are talking about bundling that as a package of work to support the NHS through the winter as well as in the longer term.

Carol Mochan: That is very helpful. Is enough urgency being placed on that to get it through quickly enough? That is the key.

Alex McMahon: I feel the urgency. Next week, the cabinet secretary will say a number of things in his announcement on winter, and I would not want to pre-empt anything that he might say. However, we are doing a lot of things now.

The Convener: A number of members want to come in on that point specifically.

Emma Harper: I have a quick question. We are planning for winter. How do we avoid admissions for people with asthma, chronic obstructive pulmonary disease or diabetes, for instance? Telemedicine is working, as is telemonitoring for folk who have COPD so that they have a plan. What work is being done to prevent folk who have asthma or COPD from coming into hospitals during winter?

Caroline Lamb: As you have rightly picked up, a lot of our focus is on how we keep people out of hospital. The remote monitoring work is important to that, and we are looking to ensure that it is appropriately spread out and scaled across Scotland.

The telehealth agenda is also important. Let us not forget the enormous success that we had with the roll-out of NHS Near Me, which went from around 1,200 consultations a month pre-pandemic and is still running at between 40,000 and 50,000. At the peak, we were running at 90,000 video consultations a month. I would like to see whether there are ways in which we can push that back up again as we head into winter so that our consultants are able to talk to folk in their own homes and we avoid people having to travel through the winter months.

John Burns: I point out the impact of the community respiratory pathway, which is well established and continues to be progressed.

Paul O'Kane: Obviously, there is a basket of approaches that need to be taken on capacity. However, I was concerned to read about the lack of surge capacity in beds, which has been identified across boards. A large number of beds from last winter's surge capacity are still occupied. How will we ensure surge capacity if required when it is simply not there?

Caroline Lamb: Without doubt, we are heading into this winter with our hospitals fuller than we would like them to be, including with the surge capacity already being stood up. Therefore, our focus is on how we can get people out of hospital faster by ensuring that, if they do not need to be there, they are not in hospital any longer, and how we prevent admissions through all the work that is going on with hospital at home, remote monitoring and remote consultations as well as the work on the urgent and unscheduled care pathways.

The Convener: I apologise to members who still have questions on this theme. We might be able to pick it up if we have time at the end, but I very much doubt that we will because we have so many other matters to cover before we change witnesses.

We will move on to talking in more detail about delayed discharges. David Torrance has some questions on that.

David Torrance: In July 2022, we had the highest number of hospital beds on record being taken up with delayed discharges since the guidance came into place in July 2016. We have heard about measures that will be taken and how much money will be put into delayed discharge, but what measures are being taken now to increase social care capacity before the winter peak happens?

Caroline Lamb: Donna Bell will want to come in on the detail of that, but I clarify that the measures that we are talking about are already in place. We are not just starting off on them; we have already taken those measures to increase investment in social care and to increase capacity.

Donna Bell: The measures are often quite bespoke, depending on the areas in question. I referred to the discussions that we have with local partnerships. Those are often quite focused. The cabinet secretary and ministers are sometimes involved, and sometimes it is John Burns and I who have those conversations.

There are underpinning measures on step-down care, improvements in care at home, multidisciplinary teams and recruitment, for instance, most of which are about ensuring that we have the appropriate workforce. All areas would say that they need to take those underpinning measures, but there are other specific actions that some are taking.

I know that John Burns and my colleagues have been speaking to NHS Dumfries and Galloway over the past few weeks and that it has reprofiled the way that it operates by providing more care at home and fewer care home beds so that it can optimise the resource that it has. Many other health board areas are considering their own provision of supporting services and increasing the number of providers that they commission. Most of that work is bespoke, because remote and rural areas will have issues that are particular to them, and areas of very high employment might struggle to recruit and might have to think differently.

I have already referenced some of the underpinning measures that are in place, and some specific service redesign actions are being taken at the local level.

David Torrance: You mentioned that 1,000 additional staff have been put in place. What evaluation has been done to see how they have helped to reduce bed blocking and helped social care services?

Caroline Lamb: Do you mean the 1,000 additional health and care support workers?

David Torrance: Yes.

Caroline Lamb: To date, we have identified where those staff have been deployed in the system. We still need to go back and do further evaluation. The same applies to get more clarity around exactly what contribution multidisciplinary teams make. We are still in early days with those investments, so we still need to assess exactly what difference is being made. However, what we hear from those on the ground and the work that Alex McMahon has been leading, which looks at healthcare support workers in bands 2 to 4, indicates that there is a lot of potential for them to take some of the pressure off our qualified nursing contingent and enable them to act at the top of their licence.

Alex McMahon: That is an important point. An example of the work is on the retire and return policy. We want to monitor how many staff would like to come back using that policy to do additional hours, and find out where they are working and how that is helping the system by improving delayed discharge rates, flow or patient safety.

We are doing work around those in bands 2 to 4 because we know that we can grow that workforce, and we are developing a career framework for that. That applies to those in band 4 in particular. We are explicitly working with health boards to identify how many staff they need and where they want them to be. That means that it is not just a case of their saying that they would like 40 staff; instead, they will say that they will have 40 staff to put in explicitly important areas to support the work that has been referenced. We are trying to ensure that we are able to monitor, count and evaluate the impact of whatever work we are doing.

Caroline Lamb: That is partly about ensuring that people have a good career pathway so that they can see ways in which they can develop their career within the health and social care system. We would like to see that being much more flexible to allow people to move between different roles as their career develops.

The Convener: A few members are waiting to ask questions. What is Paul O’Kane’s question?

Paul O’Kane: My question was similar to David Torrance’s so, in the interest of time, I am happy not to ask it.

The Convener: That is very kind of you. We will move on to a question from Stephanie Callaghan.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): I do not have one on that topic.

The Convener: That means we can move on to talk about social care capacity. Paul O’Kane will lead on that.

Paul O’Kane: The Coalition of Care and Support Providers in Scotland—CCPS—conducted a survey of its members on resilience that shows countless examples of difficulties with recruitment. What steps have been taken to address that?

Donna Bell: We work closely with COSLA and local government officials on recruitment issues. Last year, we did some work with COSLA on the joint statement of intent to work through the issues that we need to address on workforce pay, terms and conditions, learning and development and so on. At the moment, we are working with COSLA on an update to that statement of intent, which will set out the next steps for the workforce issues and improving models of care and practice. We speak regularly to the CCPS, to Scottish Care and to providers more widely about the pressures that

they are under, the sustainability issues that they are facing and viability.

10:15

I think that, like us, colleagues in COSLA, SOLACE and the third sector are all conscious of the pressures that are on the system, and we have those lines of communication open all the time.

Stephanie Callaghan: My question is for Donna Bell. Last week, I met the chief executive officer of Enable Scotland and we spoke about the high-quality self-directed health and social care that is provided through Enable Scotland's successful personal assistant model, which is an example of how focusing on individuals and building the care and support around the person's own needs and priorities can improve not only outcomes but costs down the line.

Thinking about the ambitions of the new national care service, my question is around doing things differently. First, can you give any examples of positive innovations in social care that are improving people's lives and, secondly, any examples of how scaling up such innovations could influence sustainability in the social care sector, with the national care service?

Donna Bell: Thanks for pointing out the good practice of Enable Scotland. That is a good example of person-centred self-directed support.

There are countless examples of really good innovative practice across the country that we see all the time. There are some key themes within that around person-centred care that is focused on people being able to access their rights and secure their own wellbeing.

In a number of areas, we see great support for self-directed support. We are drawing out aspects of that good practice through an improvement programme at the moment. Some areas are excellent at supporting self-directed support. It might be a good idea to provide the committee with something in writing setting out some of those examples.

There are also innovative models of care—across the country, we can see a range of different means of providing care. In some areas, very community-focused provisions are being made, including in some rural areas, where it makes sense to provide care in that way. It might be useful for us to give you a few examples of that in writing as well; I am very happy to do that.

The sustainability point that you make is a really good one. We have already referenced the CCPS and its concerns about sustainability and viability. It is feeling very tough for some providers at the moment. I was speaking to the CCPS chief exec only a couple of weeks ago, and we had a long conversation about what further support could be put in place. Some of that—the bulk of it—was about energy costs, and the UK Government has made some changes there recently. We do not have a full understanding of the impact that those changes will have, so we will need to keep in close contact with colleagues in the sector to ensure that there is a positive impact on viability.

I have been in touch with Enable Scotland more recently—just in the past week—in relation to the sustainability questions that it is asking, so that is certainly something that we can look to follow up on, to see what can be done.

The Convener: That leads nicely on to questions that we have about financial viability, given the pressures that are coming from elsewhere. David Torrance and other colleagues will ask in more depth about managing the cost increases to which Caroline Lamb alluded.

David Torrance: As well as the rising cost of energy, there is inflation when it comes to medicines and food. Do the witnesses have an estimate of the overall cost of that to the NHS in Scotland?

Caroline Lamb: We are starting to work through the cost pressures in the system that we expect next year. As you said, there is a combination of factors. There are drugs pressures and pay pressures, and there are the pressures to do with energy and inflation more generally, which have maybe come more to the fore in the past few months.

I cannot give you an estimate at the moment, but we are very focused on trying to understand the picture. My colleague Richard McCallum works closely with directors of finance in NHS boards to try to understand the pressures that they currently face and how the picture will look in future.

We are investing £18 billion in our health and social care system in the current year. That is a not-inconsiderable sum—it is up by £1 billion on previous years. Part of our approach has to involve looking at how we can be as efficient and effective as possible. I mentioned some of the work that is going on around energy efficiency and boards' opportunity maybe to consider their estates with a view to generating power from renewable sources. The climate emergency and a sustainable approach are a key priority for NHS Scotland, in terms of how we use energy and drugs and what we do about the waste that is generated around certain plastic items, for example. That is a key aspect of our focus, on which our chief medical officer is very engaged.

The Convener: Stephanie Callaghan has questions on the impact of fuel costs on the health of the nation.

Stephanie Callaghan: In relation to the cost of living crisis, the UK Government has made some changes recently, but those do not seem to do much to help the most vulnerable people. I am thinking, for example, about people who have prepayment meters, for whom the lights go off when the money runs out, and people in rural areas who have oil tanks and coal bunkers, which cost big, big sums to refill. What impact do you expect such issues to have on the national health service and social care?

Caroline Lamb: I will comment briefly on that. We are clear about the impact, from a number of perspectives. I will start with staff. The cost of travel to work might be particularly acute in the social care sector, especially where people provide care at home and move from house to house. The mileage rates that have been paid in that sector have traditionally been lower than rates in the NHS.

There is also the impact of inflation on NHS boards, which we have discussed. In addition, we are concerned that early research is surfacing the impact that worry and anxiety about not just fuel costs but inflation more generally has on the mental health of the population.

When it comes to considering winter pressures, we are absolutely mindful of those issues and the impact on people who will not be able to heat their homes as much as they need to do to stay well. We welcome any measures that the UK Government is taking to address that, and we want the UK Government to go as far as possible in doing so.

David Torrance: I have been dealing with a constituent who is on dialysis at home for nine hours every night. She needs to pre-heat the room but will not be able to afford the energy bills that she will get. Will there be additional pressure on the NHS if people like my constituent have to come back to hospital for treatment?

Caroline Lamb: As far as possible, we always want to provide treatment in people’s homes, because that is much better for them.

I will not speak definitively on the issue, but I will provide the committee with more information. I am aware that NHS boards are making additional provisions for people who get home oxygen and the additional costs that are associated with that. I am not so familiar with the issues for those who get renal-based treatments at home. We can certainly write to the committee with specifics on that.

The Convener: Okay. Tess White has some questions on workforce planning and a supplementary question on bed numbers.

Tess White: I want to touch on the issues of vacancies and retention rates. Nursing vacancies, for example, are up 25 per cent on last year, and there seems to be an issue with students at the front end. Retention also seems to be a serious issue, with 15,000 NHS workers leaving the service in the year to March 2022, which is the highest figure for a decade. So, there is an issue with the inflow and an issue with the students but there are also poor retention rates. Can you comment on that?

Caroline Lamb: I can see that Alex McMahon is itching to get in on that. I will just pass that question to you, Alex.

Alex McMahon: The issue is very close to my heart. The number of nurses in NHS Scotland is higher than it has ever been. That is a statement of fact. On your point about student nurse and midwife numbers, the process this year has, again, led us to a higher number than last year—and it is a higher number than 10 years ago. Each year, there has been an incremental increase in the number of student nurses and midwives that we have taken into undergraduate programmes. The issue is more about attrition during the programme, and that is the area that we need to focus on.

Equally, alongside that, there is the question of whether we need more than one intake a year. The system—the service that I, John and Caroline have just come from—would say that, actually, the number of students that we need is growing and that we need to grow that number. However, as a result of the pressure that that puts on staff, their ability to provide the quality of experience that is needed has sometimes been compromised. There are too many students, so we are looking at whether we could spread them out more throughout the year. We have commissioned a piece of work to look at that.

Wales has two intakes a year, for example. We are looking at that model to see whether that could reduce attrition. The reasons for people leaving the courses include their experience as a student not being as good as they had hoped and not necessarily getting the support that they want in university or their placements—and that is multifactorial, because some of it is about the academic level.

We are looking at all the things that I mentioned earlier, but we are also looking at access programmes and accelerating those. In particular, more work is being done around the Open University, which does degree programmes for healthcare support workers. We are considering whether we can increase the number there, too. Therefore, we are looking at all these factors: how we bring people in, how we keep them in, and how we retain them at the end of that.

Tess White: The retention rates are a serious issue, so can you talk about that, briefly?

Alex McMahon: I think that I mentioned earlier that we have to do a bundle of work, one part of which is on retention. We have already had some discussions with executive nurse directors but also with the Royal College of Nursing, the Royal College of Midwives and Unison about the factors that would help retention. Again, those are multifactorial, and we have probably touched on those during the course of the discussion. One of the big pieces of that work is about the hours that people work, the way that people work, how they are supported within that and, in particular, their career development—the education and training that they need to make them a better clinician in order to meet patients' needs. Therefore, it is not just about pay and it is not just about the hours—it is about a much bigger group of things.

The Convener: Tess, do you want to ask your question on beds?

Tess White: We know that bed blocking is a massive issue that affects capacity. There has been an increase of 3.6 per cent in bed numbers since last year, but we are still down by, I think, 716 beds since 2014 or 2015. Will you comment on that, please?

Caroline Lamb: I will start by saying that our focus must be on ensuring that people in hospital absolutely need to be in hospital and cannot be treated in their own bed or in a place that is more homely for them. I think that we all want that to be our focus. The pressure that we are under is partly due to delayed discharges but it is also do with some of those Covid peaks, which I quoted at the beginning of the meeting. It is easy for us to forget how many beds are occupied by people who have tested positive for Covid. We need to manage all these things in concert.

It would be wrong just to continue to increase bed numbers when hospital is not the right place for people to be treated. All the work that we have described on trying to move care out of our hospitals and to prevent people from being admitted to hospital unless they absolutely need to be admitted, and then enabling them to get back to a homely environment as quickly as possible, is a huge part of what we are doing to try to manage capacity and flow through the system.

10:30

John Burns: The only thing that I would add to that is that, when we look at the total number of beds, we see a lot of change in surgery, with more moves to day surgery, which also has an impact on in-patient beds.

The Convener: Emma Harper has a final question on Covid-19 and respiratory viruses.

Emma Harper: We are planning for the winter but are we projecting an increase in Covid cases? I was part of a team giving Covid vaccines last winter and I agree with Sandesh Gulhane that we need to encourage folk to take up vaccines, whether they are for Covid, flu, pneumococcal disease or whatever.

However, I am also thinking about other things, such as wearing masks. Instead of face coverings, should we be encouraging folk to be wearing FFP2 masks, which require fit testing, rather than surgical masks? I am concerned about what happens when we head into the winter and we are indoors again with the windows closed. I know that healthcare professionals are fed up with wearing masks already, but how do we find a balance to support everybody to reduce the risk of the spread of Covid?

Caroline Lamb: You are absolutely right that the balance is important. Therefore, keeping the situation under review is really important. Alex McMahon and his colleagues are right in the middle of that. They are working with colleagues across the UK to make the best decisions that we can.

Alex McMahon: We follow the evidence every week just to see where things are at in relation to increases in variants and their prevalence across the world. We are also trying to predict what will happen this winter and find the best evidence and guidance to give to staff and the general population.

The basics of Covid prevention still stand, including hand washing, physical distancing and wearing a face covering if you wish to continue to do so. We are also looking at the testing issue. We have eased off that a wee bit but that is not to say that we could not step that back up.

The point about FFP2 masks is not easy to answer because that relates to health and safety legislation. It is an issue that we have raised previously. We are currently using FFP3 masks, because that is the requirement for health and safety. That takes a lot of time due to face-fit testing. Actually, there are a lot of staff who do not necessarily get successfully face-fit tested for those masks. That means that we sometimes lose staff from the area that they would normally be employed in because they cannot work in that environment given the requirement to wear such masks. We are continually looking at such things.

Emma Harper: I have a final question on the procurement of personal protective equipment. My point is basically that we should shop local. Is NHS Scotland procuring our PPE from Scottish companies where possible? I know that one

company in Dumfries, Alpha Solway, was making 80 per cent of face masks. That reduces costs and emissions compared to purchasing from China, for example. Of course, there is an added cost in preparing for winter in stockpiling or procuring masks. I would be interested to hear a wee bit about that.

Alex McMahon: You are absolutely right that Alpha Solway, which is based in Dumfries, is now generating most of the masks that we wear in NHS Scotland—and indeed in other settings. That is good for the local economy but is also good for us.

We will carry out a stocktake on PPE in the next few weeks and on effective prevention control requirements heading into winter. As part of the winter response, we will be considering at what points of escalation we will need to reinstate some of the prevention measures, such as the wearing of masks in different scenarios, as well as revisiting the issue of testing.

The Convener: That leads on to a question that I was going to ask about surveillance and the public messaging around the real risk of infection. Do we need to give a clear public message that Covid is not away?

Alex McMahon: Yes.

The Convener: We also need to remember to keep doing some of the things that we got very good at doing over the past couple of years.

Alex McMahon: That is an important point. We should do that alongside the Covid vaccination and booster programmes and use those opportunities to reinforce messages to the general public—of which we are a part—for example, about the importance of hand washing, which is one of the single biggest things that we can do. Things such as masks are much further down the chain than prevention and ventilation—keeping the windows open in your house if you have people in your house.

We will go back and revisit some of that messaging that we had during the peak of Covid. As you say, it has not gone away. There may be fewer people in hospital and a slight decrease in the number of people with Covid but it is still in our system.

The Convener: I thank the panel members for their time this morning. I know that Sandesh Gulhane wanted to make a quick comment. Can it wait until the end of the next panel?

Sandesh Gulhane: It is just a very quick point. To be clear, sadly, it is not pharmacy staff who are getting double pay, but the pharmacy chains. When you write to us, could you look at that?

Caroline Lamb: Yes.

The Convener: Thank you for that clarification, Sandesh. I will suspend the meeting briefly to allow us to change witnesses.

10:35

Meeting suspended.

10:45

On resuming—

The Convener: Welcome back to the Health, Social Care and Sport Committee meeting. Our second evidence-taking session focuses on winter planning in the NHS. We have some representatives from Scottish NHS boards with us: Jeff Ace, the chief executive of NHS Dumfries and Galloway; Dr Jennifer Armstrong, the medical director of NHS Greater Glasgow and Clyde; and Dr Adam Coldwells, the deputy chief executive and director of strategy for NHS Grampian. We are covering a few different geographical areas to give us a flavour of their approaches to winter planning.

I will go around all three of the witnesses in turn. I ask them to give us an overview of their winter planning strategies and some of the challenges that they foresee this winter. I do not necessarily want them to compare the period with last winter, because last year was particularly challenging, but to tell us what their focuses will be.

We come to Jeff Ace first.

Jeff Ace (NHS Dumfries and Galloway): It is probably important to recognise that this winter will be at least as challenging as last winter. Although we do not anticipate quite the same level of Covid activity if our vaccination programme works, the acute admissions that we have already seen in the summer and autumn, and our ability to flow them through the system, give us enough reason to think that it will be an extraordinarily challenging and difficult time for our staff. Therefore, our plans are focused on how we minimise the number of admissions to hospital, how we turn around people at the front door where that is appropriate through approaches such as enhanced frailty pathways so that we can get them home, and then, when people are admitted to hospital, how we can safely discharge them as quickly as is appropriately possible.

For my board and a number of rural boards, that discharge flow is proving really difficult and we anticipate that it will continue to be difficult through the winter. That is largely due to capacity issues and the staffing issues that we are working with across the partnership. It means that, at any one time, a system such as ours probably has around three wards of individuals who really do not need to be in acute hospital settings but are there

because the appropriate community packages are not available.

That gives us the consistently high occupancy that is so difficult for staff. It is a relentless feeling in hospitals. We have to ensure that what we do in our winter plan makes the maximum opportunities to reduce that occupancy where we can. We are working on all the redesign techniques about which you heard earlier, such as enhanced discharge planning and early discharging. We are using our best forecasting techniques each day to ensure that we are able to flow patients through the system. However, the levels of occupancy that we are consistently seeing at the moment are of concern and I expect this winter to be extremely tough.

I am happy to go through any details of our plan, convener, but, to give an overview, the key worries for me, which we are attempting to address in our plan, are the consistently high occupancy, how we keep people safe as they flow in and out of our system and how we support our staff in that relentless, pressured environment.

The Convener: Thank you. As an overview, that is great. My colleagues will dig into some of the detail.

I come to Adam Coldwells.

Dr Adam Coldwells (NHS Grampian): Good morning, everyone. Our winter planning, or planning for the next six months, is based on three things. We are trying to get real clarity for the whole system about our operational delivery system. I refer to how we work on our normal objectives against our delivery plan. We have some key ones, particularly on unscheduled care and planned care. We want to provide real clarity in the system about how we try to deliver those.

We work in a portfolio—a system leadership—manner. That is how we have been trying to work for a number of years. At the heart of that is thinking about how the system works together, in hospital systems and health and social care partnerships right through to the care system. We have an operational pressure escalation system that works across all the parts of the system to try to equalise pressure between bits of it.

That is a sense of the operational bits of our system. That is part 1 of our thinking. Part 2 is thinking about our improvements. You heard lots about that from the previous witnesses and from Jeff Ace. We are redesigning our urgent care system. We are working as part of the urgent and unscheduled care collaborative and working on three or four key priorities from that national programme of work. That is all about how we optimise patient flow through our system.

The third bit of thinking concerns our contingency arrangements. How do we have surge capacity—you heard a little bit about that from the previous witnesses—for, for example, a civil contingency event? If the system was under enormous pressure, how would we respond to that? If the system is under increasing pressure as a result of high levels of admissions or its being near capacity, how do we try to raise some surge capacity?

The first two bits that I spoke about—the operational delivery system and the unscheduled care improvement plan—try to have our system run as close to normal, whatever that is, as we possibly can. That is where we try to maintain work such as all our planned care activity, which is an area of our system to which we go to increase our capacity when we are under high pressure. How do we maintain research and education—those important things that were switched down during the pandemic?

If we have to get into contingency arrangements, the question is how we draw on those in the most balanced way that we can. To give you an idea of the scale of the challenges, our contingency arrangements are the most challenging for us to deliver. We face questions such as how we draw staff in to create surge capacity, how we pay for that and what we have to turn off to do it.

That is an overview to start with. I am happy to tease into those matters through the questioning over the next hour or so.

The Convener: Before I bring in my committee colleagues, I will come back to Adam Coldwells and Jeff Ace on the challenges in rural areas with which they deal. However, first, I ask Dr Jennifer Armstrong to talk about the situation in NHS Greater Glasgow and Clyde.

Dr Jennifer Armstrong (NHS Greater Glasgow and Clyde): There is a clear planning process for winter that starts as the last winter finishes. It involves bringing cross-system groups of senior clinicians and managers together to examine what happened last winter, what key lessons we can learn and what we need to put in place.

I will talk briefly through what will be in our winter plan. The first issue that we need to address is the vaccination programme for flu and Covid. In Greater Glasgow and Clyde, that will mean that we need to vaccinate upwards of 600,000 people. We need to try to get through all those people and encourage everybody to come by early December—as you know, winter really kicks in round about January.

I should say that staffing underpins everything. Staffing is the key issue across all our services.

We are considering the staffing models that we need to deliver our services and how we can recruit.

The second issue that we need to deal with is high and fluctuating levels of Covid. Greater Glasgow and Clyde—indeed, the central belt—has been hit hard by multiple spikes. We need to consider how we model and predict spikes using the data that we have.

The third issue is the escalation plans for how we step up primary care and community care services as we get further into the winter. That involves GP during-the-day and out-of-hours services, as well as the wider community teams.

Another issue is what I would call directing away from the front door. That concerns a flow navigation centre as well as all the other things that we are doing, such as outpatient parenteral antibiotic therapy—OPAT—which we can talk about.

In relation to acute hospitals, as Jeff Ace and Dr Coldwells said, it is about maximising flow through them, as well as about the acute hospital bed plan; we need to try as best we can to open additional capacity. We then need to get people out of hospitals. There is a series of workstreams on discharge planning and getting people out of hospital by their dates of discharge, and making sure that we work with the community teams progressively to do that.

The other element is care homes. We have a care home collaborative that maximises our support for care homes in infection control and maximising capacity. We also want to protect our planned care programme over winter as much as we can, so that we can operate on as many patients as we can to address those long waits. Another thing that we do is a daily or weekly analysis of demand, so that we can predict surges as they come.

Finally, our winter plan needs a proper communication strategy, so we have a gold command strategic executive group. At the moment, it meets twice a week; during the height of Covid, it met daily. We also have that going right down GGC, throughout all aspects of community primary care and acute care, so that we can make decisions rapidly as the situation changes.

The publicity campaign is very important in trying to encourage the public—John Burns talked about the right place and right time—and is important for our internal staff communication and staff support, because it will be a very tough winter.

The Convener: I would like to pick up the rural aspect of the issue with Jeff Ace and Dr Coldwells. I imagine that you will come up with similar answers, but I will come to Dr Coldwells first. What particular challenges do you foresee health boards with large rural areas having, and how will you deal with them?

Dr Coldwells: As a bit of context, the main challenge that we have in rural areas, regardless of winter pressures and where we are at the moment, is access to provision and travel times for patients who need to access services.

In our very large rural parts, of which we have a lot in Aberdeenshire and Moray, the recruitment of staff in small communities is a challenge, be that health staff or care staff. At the moment, certainly in Aberdeenshire, we have real challenges with care staff provision. That is particularly apparent at the moment. The health and social care partnership there is working extremely hard to establish how it can create robust services while recruitment is challenged.

Beyond that, there is an issue around access to the vaccination programme, which has been spoken about a lot today. At the height of the pandemic, people were having to travel a bit, but they seemed very willing to do that. There is a question about whether that will be still be the case now. Will people still come forward for vaccinations at the rate that we want them to with the sort of distances that they would have to travel? Those are some of the initial obvious challenges that we have from a rural perspective.

Jeff Ace: We have similar issues in Dumfries and Galloway. Recruitment is a huge issue for us. We probably did not fully understand the profound impact of Brexit, which has since become very clear to us. Our competitor industries in rural areas are hospitality, agriculture and forestry, and those were quite reliant on European workers. As the original workers left and were not replaced, the impact on the workforce market was significant. We have been affected by that significantly, and have had to come to terms with that workforce shock in the midst of a much longer shift in our demographic; rural areas are getting older and our working age population is shrinking, so the pool of workers that all our sectors compete for is shrinking.

We are reliant on our ability to bring in staff from outside the region. We have had some success in overseas recruitment, but numbers are small compared with the constant demand. Recruitment is far and away the most significant issue that rural boards face.

11:00

However, the travel issue is also important. Part of NHS Scotland's service plan to meet elective waiting times involves a focus on things such as

elective centres and the consideration that patients may have to travel greater distances than previously. That is a much bigger challenge in rural areas, particularly in those such as Dumfries and Galloway, for which an elective centre is not planned. If part of the future is a significant transfer of that activity out of the region, that will cause significant issues for our population, particularly at times of high fuel costs and fuel poverty.

Those are the two issues that I want to highlight, convener. Recruitment and the ability of rural areas to sustain a viable workforce—both in the short term, as we come into winter, and over the next five or 10 years—are profound issues.

The Convener: Thank you. That is helpful, and colleagues will probably drill into that in more detail. Sandesh Gulhane has a question.

Sandesh Gulhane: Most important, what is going to happen with other things? We know that we are going to get a winter surge, but how are we going to help cancer patients, for example? Our stats have come out. The figure of 76.3 per cent is the worst on record. Clearly, it is a priority area. How can we protect those patients when it comes to winter, and get that flow continuing?

The Convener: Who would you like to answer, initially?

Sandesh Gulhane: Jeff Ace, initially, because he is nodding, but it is for all the boards, I am afraid.

Jeff Ace: It is critical that we look at it by cancer pathway, almost, because there are specific problems and pinch points in some of those, and they need separate fixes. For example, for us in Dumfries and Galloway, colorectal cancer is an issue, and our link for that is with NHS Lothian, so we need to make sure that that pathway has the right capacity.

It is important to chunk down the cancer journey problem into each of the tumour site pathways—particularly for a rural board such as mine, for which a lot of the specialist complex care takes place either in Glasgow or in Edinburgh—and to ensure that, at each stage of that pathway, whether a diagnostic stage or a treatment stage, we have the right capacity and clarity in the pathway.

Although, as Sandesh Gulhane has, rightly, pointed out, the overall stats for cancer as a whole are not where we want them to be, the critical thing is to look at breast pathways, colorectal pathways, lung pathways and so on, and to ensure that the demand capacity modelling is accurate and that we do not have blocks in the system that cause us difficulties. At the moment, two or three tumour site pathways cause us particular problems—as they probably do across Scotland—and that is where we should focus our efforts, to make the maximum impact on the overall figure.

In Dumfries and Galloway, we have been relatively successful in being able to ring fence our local capacity. For cancer, as I said, because of the complexity of the journeys, the tertiary centre and the local centres all need to work in the same demand-and-capacity model, to get the rapid access that patients need.

There are some rays of positivity. We are a pilot project area for early detection—one of three or so such pilots in Scotland. That is showing some positive results. We are able to take cases that GPs are concerned about but that do not fit with the classical cancer rapid referral guidelines, by referring those into multidisciplinary clinics locally. That is showing a good detection rate for the amount of investment that we are putting in. I am very excited about our ability to spread that across Scotland.

As you know, compared with the rest of Europe, the UK is a poor performer in the early detection of cancer, and that is one of the areas in which we can make rapid gains. We have huge challenges, particularly in a number of tumour pathways, but, in the midst of those challenges, very good work is going on to understand capacity, fix capacity gaps and look at problems slightly differently, through the early detection lens.

The Convener: If other colleagues on the panel want to come in specifically on Sandesh Gulhane's question, they are welcome to do so. I will go first to Dr Armstrong.

Dr Armstrong: It is an area that we put a huge amount of work into, because it is very important. As you remember, when the first Covid surge hit, cancer treatment was not stepped down, but a lot of other activities were, so that left us with a backlog. Jeff is absolutely right that there are different issues for different tumour groups, and I will give a few examples of what we are doing to maximise cancer capacity.

In Greater Glasgow and Clyde, we have maximised the use of endoscopy. In May, a brand new unit started in Gartnavel—just down the road from me—to maximise the throughput for endoscopy, because endoscopy is a key investigation for a lot of bowel cancers. We have also looked at the Golden Jubilee national hospital to maximise endoscopy use and sessions there.

In addition, there are things such as the breast cancer activity pathway. As part of that, we hold weekend clinics and help other boards to do so. We hold weekend clinics to ensure that we keep up, so that women are not kept waiting to be seen, because it is an extremely worrying time, as

members realise. We also run lots of weekend sessions for prostate cancer treatment—we are trying to maximise everything that we have.

In addition, we are maximising imaging capacity, because that is a key indicator for detecting cancer. The Beatson centre, which is at the Gartnavel campus, has helped us during Covid, because we made that a green site as much as we could.

In answer to the broader question that was asked about winter, for things such as theatres, in Greater Glasgow and Clyde, we have two ambulatory care units—one at Stobhill hospital and one at Victoria hospital—as well as ambulatory facilities at the Vale of Leven hospital, Inverclyde royal hospital and Gartnavel general hospital. We are trying to maximise use of those facilities in order to protect patients as surges happen at the other sites. We are really keen to do that and, at the moment, we are working with the anaesthetists and clinicians. The chief of medicine for Glasgow royal infirmary, who is also a surgeon, is developing lots of ambulatory care pathways. We also want to make sure that pre-op assessment is right, because we do not want somebody to turn up to take a theatre slot, only to find out that they are not clinically well enough to have the procedure. A huge amount of work has been done, and we have done a huge amount of modelling. We are doing our best to catch up and to protect capacity over the wintertime by doing things differently, as well as doing them on other sites.

Dr Coldwells: I probably have nothing to add to what Jennifer Armstrong and Jeff Ace have said about specific cancer improvements, because similar things are happening in Grampian, but I will spend a moment on the winter context.

At the moment, our tactical approach to winter has a really clear aim not to disrupt elective care. In order to avoid disrupting it, we are trying all sorts of improvement activity around unscheduled care. We are testing all sorts of things and getting them in place, by drawing on a wide clinical community, which is co-designing and establishing a way to improve the flow through the hospital and into the community. We are also doing all the stuff that you have heard lots about this morning, with regard to trying to prevent people from coming into hospital.

If that work is successful—which, obviously, depends on demand—our next bit of planning is based on four scenarios that we are thinking about. If I share those scenarios now, it might help with the context.

The first scenario is our best case. Our system has remained at an absolute high level for many, many months, and our best-case scenario is that that maximally stressed system is like winter demand and continues without further stress.

In our second scenario, we are thinking about a standard winter surge on top of that high demand. Such a surge would relate to falls, trips and the normal cardiovascular and stroke events that increase in number through winter.

In our third scenario, we are thinking about a winter involving a respiratory virus, such as flu or a Covid variant.

In our fourth scenario, which is very new for us, we are thinking about how the cost of living crisis could place sustained stress on our system, given that there will be increased pressure over winter and potentially for much longer.

Planning in those four areas is on-going. We are thinking about what we could do, in each area, to minimise the disruption to elective care if there was a surge and we faced a peak for a certain duration. As the committee knows, we already use a prioritisation system, which was described earlier, for surgical activity. Cancer prioritisation is high, because the ESCAT—the ESMO scale for clinical actionability of molecular targets—level that people get is high. The consequence of that for other people who absolutely need an operation will be terrible, but, in clinical terms, the impacts will be slower and there will be a longer-lasting effect. The big worry relates to people who end up with long waits and are in distress, but, in strict clinical terms, the right prioritisation takes place.

We are trying to plan as well as we can to minimise the disruption during winter and avoid a surge, because, historically, given our constrained system, that can affect elective care quite often. It is very difficult for us to get any mutual aid, because we are quite a long way from big centres in Dundee and the Highlands, although, in the north, we are closer to Dr Gray’s hospital, which provides quite good mutual aid.

The Convener: We will move on to questions on funding. I ask that members direct their questions to particular witnesses. If other witnesses want to come in, they should put an R in the chat box so that I know to bring them in. With the best will in the world, I do not think that we will have time for every question to be answered by all three witnesses, but it was useful for that to happen on the previous two occasions because it gave us an overview.

David Torrance: What evaluation have your boards made of the impact and effectiveness of the additional winter plan funding that was provided in 2021-22? I will go to Adam Coldwells.

Dr Coldwells: I just want to check that I have understood the question. Are you talking about the value of the funding from last year?

David Torrance: Yes.

Dr Coldwells: Thank you. As Jennifer Armstrong described in her opening answer, at the end of each winter, we do an evaluation. All the communities, including the acute hospital community, clinicians, managers and support staff, come together for a formal debrief to explore what has worked well and what has not worked well, typically with an eye to thinking about what we might do in the future. As part of that, we look at the additional measures that we have put in place for winter and how we have spent the money. We then assess whether we are likely to put in place those measures again for future pressured events. Typically, we speak less and less about "winter" and, more and more, use "pressure" and "surge" as our common language.

We do not do an assessment of quality-adjusted life years and values such as that, but we certainly look at how we have spent the funding, what has been useful and what we are likely to use again. Last year, all sorts of additional capacity were put in place in posts and roles to try to increase flow through the hospital system and to prevent people from coming in. Off the top of my head, I cannot think of what was most useful and what was not useful, but that consideration has fed into our planning for this year in relation to how we are likely to commit resources in the coming surge period.

The Convener: If anyone would like to highlight any additional work that they are doing in their health board, please let me know.

11:15

Dr Armstrong: We did a very detailed cost assessment of winter and what happened last year. As Adam Coldwells was saying, one of the complicating issues is that Covid continued through last year. To give you an idea of the likely scenario for 2022-23, we anticipate about £8.4 million of costs. That includes £2.4 million for the period from April to November, which relates to the additional beds that we kept open. We would normally be able to close them but, due to the surges that we experienced, we could not. Our usual cost is around £6 million over winter, so that gives us a total of about £8.4 million.

We anticipate getting around £2.2 million from the Scottish Government, which leaves a figure of £6.2 million for the board to fund. Most years, we have to do that, and we have to put it into our financial plan going forward. The key for NHS Greater Glasgow and Clyde is that we have to fund winter across the board, including additional beds and staff, to mitigate as much as we can. Those are the calculations that the director of finance has done, and that is what we are thinking about.

Jeff Ace: The key thing is to look at boards' underlying financial positions at the moment. From my perspective, it is really hard to see us in sustained financial balance. It is probably unhelpful to look at different allocations and say what is for winter and what is for other things. If you look at the entirety of our funding against the entirely of our projected costs, I probably have a bigger gap than I have ever seen in my time as chief executive.

As well as the urgency of planning how we get through this winter in reasonable shape—keeping our elective flows going and keeping our non-elective patients safe—we have to do a major piece of forward planning on how we reconstruct the health service to live within that overall allocation. From my perspective, that will mean a service that is redesigned with £20 million or £30 million less in costs, which, on an overall turnover of barely more than £350 million, is a big reduction.

It is almost as though we are on two tracks at the moment: how do we survive this year as a safe service that can meet its targets, and how do we reconstruct ourselves into a service that is sustainable in workforce and financial terms. That is the difficult trick that we are trying to pull off at the moment.

David Torrance: Where would you consider that any additional investment could have the most impact on winter pressures?

Jeff Ace: It will probably be different in each of our boards. For us, the ability to discharge safely from hospital would have the most significant and immediate impact. For that to happen, we would need very large increases in care capacity. However, it is not solely a money problem; it is about our ability to recruit and retain in those sectors. Money would be enormously welcome, and that is where I would direct it to, but I am not sure that I can rapidly solve the problem, because it will require recruitment campaigns to have greater success than we are having at the moment.

The Convener: I will go to Adam Coldwells next and then to Jennifer Armstrong. Adam, I imagine that you will say similar things with regard to care capacity, given that you have mentioned it already. However, I do not want to pre-empt your answer.

Dr Coldwells: Similar to what Jeff Ace said, the key place to spend money would be staff, from community settings and care settings right through to hospitals. Our really big challenge is recruiting people. We definitely struggle to recruit across the whole spectrum of people who make health and care work successfully.

Money absolutely is a worry this year, again. Jeff set the context really well. Our overall financial position is definitely a worry for us, and trying to redesign the system for a different financial envelope certainly adds to the pressure. The speed at which we can do that is a concern. Planning is my daily bread and butter, and that is a real challenge for us.

Dr Armstrong: When we plan for winter, we have to try to balance the impacts of the funding that is available to us. Jeff Ace is absolutely right about that.

For example—and we might come on to talk about this—we have 300 delayed-discharge patients in our hospitals at the moment, which is up from 50 last year. For many of those patients, it would be far better to be in an intermediate facility where they could get rehabilitation and be in a much more homely environment than an acute hospital can offer. Three hundred beds is about two floors of the Queen Elizabeth hospital, which are staffed with doctors and nurses for acute-care patients. Intermediate facilities and social care would be extremely helpful.

Staffing is an issue if we are to improve patient safety as much as we can. I think that the committee has heard about out-patient parenteral antimicrobial therapy. OPAT is an extremely good initiative: it is saving us about 50 beds a day and giving patients a far better experience. As we roll it out across Clyde and the Royal Alexandra hospital, it could save us up to 100 beds a day.

Other initiatives are also good but save us hardly any beds per day, so we ask clinicians and managers to do impact assessments on each feature. A debate that we had recently with allied health professionals was about putting additional AHPs into an acute sector so that we could rehabilitate patients more quickly and get them out.

We are always trying, I think, to maximise the impact on patient safety while helping staff as much as possible, because it is going to be a tough winter. All those things come into the mix when we make decisions. As I said, at GGC we accept that we have to spend a lot of money in winter to try to keep patients safe. That is why we put that into our financial plan.

The Convener: Emma Harper has questions in a similar vein, on managing cost increases.

Emma Harper: Good morning, panel. I suppose that my questions are on a similar theme, in that they are about boards juggling and keeping all the plates in the air. Financial issues are now compounded by the energy cost increases. To what extent do you anticipate that facility costs will increase over the winter, in your planning?

I think that health boards have climate change or net zero groups that consider where savings can be made. I think that NHS Dumfries and Galloway has such a group—Jeff Ace will be able to confirm that. What impact will rising energy and facility costs have on finances as we move into winter?

Jeff Ace: They are certainly increasing the gap. I spent the time before this meeting in a meeting with my estates leads, looking at options for different fuel solutions—for example, for the central sterile services department—to try to reduce the cost of instrument sterilisation. I guess that there is a constant double pressure of trying to reduce costs by reducing activity or finding a cheaper means of energy production and considering the carbon target that we have. You are absolutely right: each board has a carbon reduction group, an executive lead and a champion, who are looking at how we can achieve the net zero target over the coming decades. Fortunately, that activity comes with cost reduction; the two things are mutual goods and we can link them in a lot of cases.

The big challenge is hospital heating. That is where the intensity of energy generation is such that gas is the perfect solution and everything else is less good at the moment, given where the technology is. It is hospital heating that is giving us long-term worry about how we reduce costs and carbon. We can align much of the rest of our energy bills and carbon usage so that we spend less and emit less. The problem we really need to crack is hospital heating.

Emma Harper: If Donna Bell had been on this panel, she would say that there are real challenges with maintaining heating in care homes.

On long-term, sustainable solutions, I know that NHS Orkney has solar panels on its hospital. Is that being planned for other hospital estates, such as those in Dumfries and Galloway or in Grampian?

The Convener: I will bring in Dr Coldwells to talk about what NHS Grampian is doing to manage the soaring energy costs.

Dr Coldwells: In the very short term—as in the next month or two—we are very limited in what we can do. We are facing enormous rises in cost. I want to say a figure, but I might not have it quite right in my head, so I will not say it out loud. We are facing many, many millions of pounds of increase in the energy bill this year. I agree with everything that Jeff Ace has said—it is the same for us.

We are looking at two other things in the environmental group: single-use items—we use an enormous number of single-use items and the

group is exploring what we can do differently to improve our green footprint—and travel. During the pandemic, when we went to largely digital clinics, we saved 13 million miles of travel. That relates to the carbon footprint, rather than heating, so I have slightly gone away from your question, although it is in the green space. There was a huge carbon dioxide reduction just from patients not travelling to and from clinics across Grampian, which is a big patch. The more we can stick with the digital approach, where that is appropriate and works for people's choices, the more we can support a big carbon reduction, on top of all the work that we need to do on heating.

One of the challenges with solar power is the priority of capital funding—it would need quite large sums of capital funding. There is huge pressure on our capital allocation across our whole estate and it is difficult to prioritise investment in solar over what we need to spend money on in the here and now in an estate that is quite old. There is a real tension there between the direction that we would like to go in and some of what we are forced to do in an annual cycle of capital spending.

Dr Armstrong: I am sticking my neck out a bit here, but I think that the additional energy costs for NHS Greater Glasgow and Clyde are something like £19 million—that is over and above what we currently pay for energy. That is the figure from our director of finance, but I can check it for the committee.

Following on from Adam Coldwells's point, NHS Greater Glasgow and Clyde has an active strategy to reach the net zero target. There is a lot of clinical involvement in that, too. However, with old estate, there is a need for capital investment to change from fossil fuel boilers to something more green. We can do that in our newer hospitals and we have got it in our newer hospitals. As we build new estate, we need to ensure that it is energy efficient. However, for a lot of the older hospitals, the change to net zero without additional capital investment will be challenging.

The other thing is that we need to look at the sorts of skills that are needed on boards and in estates departments in order to make that change. We need to look across Scotland to make sure that we have that capability.

The Convener: Thank you. Let us move on to the effect of the cost of living crisis and fuel poverty on people's health, which is something else that will need to be factored in.

Stephanie Callaghan: I have two questions that I will ask together, which will hopefully speed things up a little. Earlier today, Caroline Lamb highlighted the negative impacts of the current cost of living and fuel poverty on wellbeing and on mental health in particular.

My first question is about patients. What increases in demand do you expect to see in relation to mental health support and primary care services over winter, and how does your board plan to manage them?

My second question is about staff. What impact will increases in living costs and fuel have on NHS staff, and what actions is your board considering to support employees over the winter months?

I will start with Dr Armstrong. Jeff Ace and Dr Coldwells are of course welcome to add anything.

11:30

Dr Armstrong: Those are very good questions, which are absolutely relevant. Greater Glasgow and Clyde already has a deprived population. I have seen some modelling, but I am not yet cleared to share it. We have seen an increase in the number of food banks and in mental health issues across the population, and we expect fuel poverty and food poverty to have a significant impact on our population—particularly in Greater Glasgow and Clyde—as more families are pushed into fuel and food poverty. That has an impact on chronic illness. I know that we all know this, but if you are in a cold house and you have asthma or COPD, or if you have young children or dampness, it will increase the amount of morbidity in the population. In addition to that, the Royal College of Physicians did good surveys that showed very clearly that, if you are in debt, your mental health is far worse. Those are obvious points.

As to supporting people around that—we have also thought about how we could support staff—we are trying to increase our mental health support. We produced a mental health framework as part of our recovery planning, and our public health colleagues are considering what we can do to alleviate child poverty in particular, such as looking at how we can use all the NHS interactions to get benefits out to people.

In relation to primary care, we offer around 110,000 appointments a week in Greater Glasgow and Clyde, around 46 per cent of which are face to face and around 55 per cent of which are by telephone. We are trying to prioritise the patients who really require our support by working with third sector colleagues. There is a whole plan around that to try to mitigate the impacts.

We have staff who are concerned and worried, and we are trying to ensure that they have access to financial support. I believe that all of our staff are on the living wage, but we know that there

may well be further industrial action over the winter. We will wait to see the outcome of that.

With regard to staff mental health support generally, we have a whole programme that we put in place for Covid. That is about peer-to-peer support, helplines, psychology support, rest and relaxation hubs, trying to support people individually and mental health check-ins. We have done a whole series of things to try to alleviate that as much as we possibly can.

We will try our best. We will have an NHS side of it, which is about patients, their families and the communities that we serve in Greater Glasgow and Clyde. We are trying to ensure that we support them as best we can right across all of the services, as well as support our staff. For example, we are setting up services such as financial advice services for them.

Jeff Ace: I do not have much to add to what Jennifer Armstrong said. However, I emphasise her point about child vulnerability. The experience for our children in Scotland over the past three or so years has been incredibly tough, with disrupted schooling and lockdown; now, there is a period of potential austerity and poverty. That fits with all of our understanding of adverse childhood events, and we now have good recognition of what that can mean for both mental and physical health needs as the child progresses.

We have a real risk situation in relation to our childhood population health, which we need to make sure that we understand. We also need to make sure that our mental and physical health services are adapting and expanding where appropriate to meet that. I am really concerned about the most vulnerable of our children, who have had an extraordinarily difficult three years. For us as key agencies, trying to keep them safe has to be a focus, but it is a big problem.

Dr Coldwells: I do not have anything to add, convener. Jennifer Armstrong and Jeff Ace covered it well.

The Convener: They are universal issues.

Paul O'Kane: I want to explore that mental health point a little further. I will ask about people who will inevitably end up in crisis due to cost of living pressures. Because it ties into trying to reduce attendances at the wrong place, I am keen to understand what work the boards have done with third sector providers on the support that they can give to deal with crisis. I am thinking about organisations such as local mental health associations, which already run some of the relevant services.

Given my local interest, I will start with Greater Glasgow and Clyde and Dr Armstrong.

Dr Armstrong: I know that this is not quite what you asked, but one of the key things that we did on crisis support at the beginning of the pandemic was to introduce mental health assessment units, which has worked extremely well. There is one based at Leverndale hospital and one at Stobhill hospital. Those units run 24/7 and have made a huge impact on how we deal with people in severe mental health crisis. Before, they used to be picked up by the police, would have to go to ED and face long waiting times. I saw cases of people who were really distressed, and you do not want to be in a loud environment at that point.

We brought the crisis support services together. We have advanced nurse practitioners who support people. I visited the sites and have watched them; they are excellent. They assess people who are in mental health crisis. I think that we see around 300 patients a week in the mental health advice centres. We have done a safety evaluation of those units and they look pretty good. About 60 per cent of the patients are already known to the service. We have developed much stronger links between the GP out-of-hours service, GPs and the mental health assessment units so that GPs can now refer directly to the assessment units. That is a much better way of dealing with people.

A lot of work has been done with the third sector. It is extremely important for ensuring that people get access to suicide prevention services and peer support work. We can give you more detail on that. We are working with various third sector groups to do that. Among the mental health services, we do a red-amber-green pathway, in that we try to prioritise the patients who we believe really require our support.

A lot of work has been done, and we are also doing work in schools. That relates to the point that Jeff Ace just made. Parts of our HSCPs are more advanced than others. The work includes supporting children in schools while they wait for other appointments and trying to prevent issues more than we have before.

NHS Greater Glasgow and Clyde is implementing a mental health strategy and we are trying to develop the primary care community teams, which work with GPs and schools to support mental health. We can give you more detail on that later.

The Convener: If the other witnesses want to comment on anything that they are doing locally, they are welcome to do so. Otherwise, we will move on to our next question, which is on accident and emergency waiting times.

Emma Harper: I asked the previous witnesses about the challenges that we are experiencing in accident and emergency. Knowing how to move

people through the system—whether you bring them into A and E and discharge them if possible or move them into acute beds—is a complicated matter, and given what the previous panel said, I am interested in hearing what this panel thinks is driving the increased delays in A and E services.

Jeff Ace: Occupancy remains the biggest challenge for us with regard to our A and E activity. You will not see any huge step up in our current levels of activity to pre-Covid levels; the pattern is fairly consistent. However, we are seeing an increase in acuity and a slight increase in the age of patients who are presenting, and they will require more acute intervention and admission to hospital. With our consistently high occupancy, that is where the blockage comes.

Traditionally, in rural health boards such as mine, our highest numbers for A and E attendance are in the summer, with the influx of tourists. However, that does not generate a significant number of admissions, because the injuries involved are largely of a low level or relate to incidents with young people. This summer, there was a sustained high level of activity alongside a much higher number of admissions into what was an already hot system—by which I mean, one of high occupancy. That is what caused our traditionally very good four-hour performance in Dumfries and Galloway to dip. Normally, our baseline would be 90 per cent—occasionally, we achieve 95 per cent—but this summer it was much closer to 80 per cent. In fact, we were at times below that figure.

Last weekend—the weekend before the Queen's funeral—we had probably the worst performance on record in Dumfries and Galloway, because we had a consistent number of patients requiring significant treatment in A and E as well as onward admission. Our ability to admit those people into a system already close to 100 per cent occupancy was limited.

If you did a full diagnosis, you would come back to the fact that two of the key drivers of our A and E performance are out-of-hospital capacity and capacity with regard to our ability to discharge patients effectively. We sometimes fall into the trap of seeing the A and E headline figure as a problem that needs to be solved when it is important to recognise that, in reality, it is a symptom of a multitude of problems that need to be addressed. It is important that we do consistent systemic work to ensure that there is a safe flow of patients both through the system and when they return to their homes and that things are operating effectively. If that does not happen, we will have a logjam in A and E, with patients having really long waits and very poor experiences and our staff under what feels like an astonishingly consistent level of pressure.

A and E attendance is a key metric for us in considering the system's health, but you cannot fix that in A and E. You have to fix the systemic journey for patients, all the way back to their homes.

The Convener: If none of the other witnesses wants to talk about their areas, I will go back to Emma Harper, who has a supplementary question.

Emma Harper: It is sometimes difficult to see whether there is going to be light at the end of the tunnel. Should we just accept that the levels of attendance are high right now and that that situation will continue all through winter? Part of getting people out of hospital involves working with our social care teams, and that will include falls assessments and prevention and the other things that we can do to support people to get back to their own homes. What about the pressure on demand and the resulting impact on everyone across the service? Are there any other mitigating measures that you think could be implemented in that respect?

The Convener: As Dr Armstrong is nodding, I will bring her in.

Dr Armstrong: What Jeff Ace has said is absolutely correct. At the moment, there is a logjam in the EDs. I have spoken to many ED consultants and nurses, and I know that the pressure on them is absolutely enormous and that their ability to deliver the sort of safe patient care that they want to deliver is being compromised.

In Greater Glasgow and Clyde, roughly 6,500 people attend EDs every week, whereas at the flow navigation centre, we deal with about 300 patients every week. We need to flip that around, because of the 6,600 or so patients who attend EDs, around a third are what we call flow 1, which means that they have minor injuries and illnesses. We need to give patients a better service.

I have seen the publicity campaign about triaging patients before they even come to us, and I think that such an approach is far better for patients and hospital services. In the FNC, which goes through NHS 111, we can say to patients, "Come up to the New Stobhill hospital ambulatory care and diagnostic centre at 1 pm, and you'll be seen right away." That is a much better service. Minor illness should probably really be dealt with in primary care but, because patients are trying to get treatment, we need to get far better at that, and it will take time for us to develop those services.

11:45

In NHS Greater Glasgow and Clyde, there is a high conveyance rate for falls and for patients from

nursing homes. We are doing a lot of work with the Scottish Ambulance Service and the flow navigation centre to give clinical advice and make sure that such patients come to us when they need to and do not come when they do not need to.

There is a whole range of things that we can do prior to patients coming in. Once they are at the front door, we have frailty assessment services, in which expert teams work directly with the community teams. An 85-year-old person who has had a fall might be better off in their own home, with rehabilitation people helping them get out of bed and get their muscles moving. At the heart of the issue is what is best for the patients.

Through the Consultant Connect system, we have a series of apps that GPs can use to contact and get advice from consultants within half an hour. I spoke to the area medical committee about it last week, and it believes that the system is working well but that it will take time to bed in, because of the need to do certain outward things.

Bed capacity is a real issue. As I have said, when we have 300 patients who could be better managed elsewhere, we get an exit block. Going back to the points that John Burns made earlier, I think that there are things that we have to do more rigorously, such as discharging patients before 12 o'clock. If patients are in bed and there is a surge coming—if you look during the day, you can see what time patients will come in—you get both an exit block and an assessment block, and then you have an overcrowded department. Our ED and paramedic staff have been excellent, and they do their best day in, day out under extreme pressure to manage the situation.

It is a complex problem, and the NHS needs to change. I am not sure that we can do it all for the coming winter, but we need to do it in the coming years to ensure that we manage patients in a much better way. That is for their sake and for patient safety, which is crucial; however, to go back to John Burns's point—which was absolutely right—I think that it is also about the right time, the right place and the right person. I know how that sounds, but it is true. It would be helpful if, in this winter's publicity campaigns, the Scottish Government could encourage people to use some of the new pathways.

The Convener: We must move on. Tess White has a question about A and E, and then we will move on to talk about waiting times and cancelled operations.

Tess White: Jeff Ace and Jennifer Armstrong have mentioned the A and E logjam, but my question is for Dr Coldwells. Right now, there are reports of at least 10 ambulances waiting outside the A and E department at Aberdeen royal infirmary, and it is becoming a big logjam—in fact, it is a crisis. The public are being asked to go to A and E only if the issue is life threatening. What actions are we taking to address that now? We are facing winter, and that will exacerbate the issues. The pipe is bursting now, but there will be an explosion in winter, unless we have immediate plans and think about what we are going to put in place for A and E at ARI.

Dr Coldwells: Jeff Ace and Jennifer Armstrong have described the flow challenge through the whole system, but perhaps I can give a tiny bit of context with regard to the Grampian system. During the pandemic, we reduced our bed base quite dramatically, a step that was associated with infection prevention and control measures. As a result, we are now operating close to maximum bed base capacity all the time, so there are issues with flow through the system. Everyone is familiar with the M25 analogy and the idea that things do not work anything like as well when a system is very full or busy.

We are taking four key actions at the moment to try to improve the flow at ARI. As Jennifer Armstrong has said, when an A and E department gets busy or there is crowding, as it is commonly known, efficiency also deteriorates; however, the issue is really the flow through the whole system. We already have in place hot clinics for particular specialities in which we consider whether we can move people on to an urgent flow for treatment on a scheduled day—that is, later that day or the next. We are trying to expand those things to give people rapid access to something that might provide a different route other than through admission.

We are also looking at putting in place a very different multidisciplinary triage and assessment process. It is an approach that has come and gone over the years, but we are having another go at putting in place a really strong multidisciplinary team that is drawn from across the hospital. It is one of the key things that has come out of all the work that we have done with a wide clinical body to think collectively about what we can do differently. It is very much about the front door to care and how that can change people's journey early in the system.

The next thing that we are doing is increasing hospital-at-home capacity. We are trying to increase that capacity by 100 spaces in the city, which will have a good impact on the flow of people through the system. We are actively working on that to increase capacity rapidly.

A local issue that we have is a real backlog in cath lab activity. We have an opportunity to increase that capacity, which would get the flow moving through cardiology much better, and a targeted bit of work on that is under way. The

approach is slightly different. There might be a little bit of investment for that, and a slightly different staff group is involved to help improve things, but, with the backlog, that activity is absolutely stuck at the moment. Actually, the challenge is not just in cardiology, but in pretty much every specialty. That said, it looks as if there is a real opportunity to potentially improve things.

I have given four examples of actions that we are taking. We have a really big multidisciplinary clinical and managerial team that is working together to explore what improvements we can make to reduce people's wait in A and E. As everyone has been saying this morning, that is a really good indicator of the busyness of the whole system. There are busy aspects in primary care, in secondary care and back into community care.

The Convener: Gillian Mackay has some questions on waiting times and cancelled operations.

Gillian Mackay: Those listening earlier will probably recognise this question, because I put it to the first panel. During the pandemic's most acute period, we had really good information at national level about services and what patients' care would look like, and a lot of people valued that. Many will understand why operations have to be postponed, but some constituents feel that information on next steps and the other support that is available while they wait for a new operation date is not what they would like it be. What work is being done at health board level to ensure that patients have information on how to keep themselves well and how to get support while waiting for an operation? I also want to link that to Emma Harper's earlier question and ask: what communication is being provided on urgent care?

I will direct that question to Dr Armstrong, given the size of NHS Greater Glasgow and Clyde.

Dr Armstrong: As far as planned care is concerned, you are absolutely right: a large number of patients have been waiting for a considerable time. We are developing much more information on how patients can keep themselves healthy, including through exercise and diet. One of the anaesthetists is leading quite a lot of work on that, and we can signpost patients to it.

We are also developing with the Scottish Government a Scotland-wide app with which patients can access care, but it is not ready yet. I know that a lot of work has been done on it, but I am not quite sure where it has got to. In any case, it aims to cover all the different pathways and signpost people to relevant care.

As I think that John Burns has mentioned, we are also working on, for example, patient-initiated contact to keep patients as well as we can. I have already mentioned that we are looking at pre-op assessment, too, so that we see patients early.

We are trying our best to ensure that we look at not only the urgent categories but people who have been waiting a long time, so that we deal with what you might call that tail of patients. We are very conscious that one of the worst things that we sometimes have to do in the middle of winter is to cancel operations; indeed, you will see headlines in the media along the lines of "GGC Cancels Operations". Everybody feels for those patients; we know that they have waited a long time, and we try to book them in again as soon as we can. That is roughly what we are doing as a board to try to get people to exercise, diet and put themselves in the best possible space before getting an operation.

The Convener: Thank you. Sandesh Gulhane also has a specific question on this issue.

Sandesh Gulhane: My question is for Dr Armstrong, mainly because NHS Greater Glasgow and Clyde is the biggest board. With regard to waiting times, Dr Iain Kennedy, the new chair of BMA Scotland, has said that figures that have been compiled suggest that patients are not getting a realistic picture of the delays with orthopaedics, and orthopaedic surgeons are saying that only the most urgent care is being prioritised while patients

> "face languishing on waiting lists for years due to lack of capacity."

How do you respond to that and what can you do to ensure that we get those waiting lists down?

Dr Armstrong: NHS Greater Glasgow and Clyde has developed a waiting list plan and, as you know, there are waiting list targets. There is no doubt that there is a huge backlog, particularly in certain specialisms such as orthopaedics, which you have just mentioned.

NHS Greater Glasgow and Clyde has developed a waiting list plan with the Scottish Government and has asked for additional support; we have asked for Golden Jubilee hospital support and other support to try to mitigate and tackle the backlog. Patients are clinically prioritised. That was a recent change by the Scottish Government; we had the Royal College priorities P1, 2 and 3, but the process has now changed. We now ask the clinicians to prioritise, and we try to get as much capacity as we can. We have a theatre capacity plan in which we try to allocate capacity first to cancer patients, as well as to other patients on the theatre list, and we maximise use as much as possible.

That is our plan and we are trying to stick to it. However, there is no doubt that, as with every other board across the UK, we still have a big

backlog of patients that it will take us time to work through.

The Convener: Staffing has been mentioned by many people and we have given it a good airing, but we have some specific questions on retention and the pressures on staffing.

Paul O'Kane: I have two questions that I will ask together, if that is helpful. How resilient are boards in terms of staffing numbers over winter, given the challenges that we know persisted last winter and over the course of the Covid period? I am particularly interested in single staffing of wards and some of the data around that. Secondly in terms of resilience, staff wellbeing was alluded to, but to what degree have there been innovations such as the provision of meals for staff on night shift and rest areas?

The Convener: We will take each health board in turn.

Jeff Ace: This is a key question when it comes to our ability to successfully navigate the winter. There is no doubt that our staff are under extraordinary pressure. We are currently unable to staff our core functions—not just in acute care but in mental health services. We have already talked about social care. At the moment, we are not able to guarantee a resilient level of staffing that allows us to deal with routine sickness and annual leave. Staff have been dealing with gaps consistently since the pandemic. That has a knock-on effect on staff wellbeing and on their ability to remain resilient and to keep themselves well.

The key challenge, for rural boards in particular, is how we maintain a staffing level that allows us to provide safe high-quality care. That is not just about recruitment but about retention and how we work with staff who are coming to the other end of their career and how we introduce enough flexibility to allow them to feel that it is still a good place for them to work and that they can continue to contribute as they would wish.

I speak for NHS Dumfries and Galloway and I do not think that we are anywhere near where we need to be on that at the moment. We have to create a much more flexible environment for staff, to ensure that our retention rates match what we need to make up for our difficulties in recruitment. We have got better at that, but we have a way to go before we are an exemplar in that area.

12:00

Your point about staff wellbeing is important. During the pandemic, extraordinarily good stuff was going on throughout Scotland in how we supported staff. Jennifer Armstrong mentioned psychology support and prosocial models. We have kept those on post-pandemic.

However, I emphasise that it is important that if, when staff come to work, not enough of their colleagues are on shift to provide the level of care that they would want, anything that we try to put around them to mitigate that stress is not good enough. We need to make sure that those staffing levels are right. That is where we are struggling at the moment.

I agree that there should be a focus on what additional things we can do for staff wellbeing, but the most important thing is to reduce occupancy in our hospital environments, provide the right level of staffing in our community and social care environments, recruit effectively and support people towards the end of their career so that they do not feel that they need to leave in the numbers that they are currently leaving. That is the key to staff wellbeing that we all have to get better at, in what is a much more competitive environment when it comes to the workforce.

The Convener: Thank you. I do not know whether anyone has any points to add to what Jeff Ace has said. As with many other things, the issues are probably similar across all health boards.

Dr Coldwells: I agree with Jeff Ace, who framed it really well. We face exactly the same challenge. He said it very well.

The Convener: Paul, are you happy for me to move on to your colleagues to ask some supplementary questions on that?

Paul O'Kane: Sure.

Tess White: I, too, thought that Jeff Ace gave a good answer, but my question is to Dr Coldwells.

NHS Grampian has record staffing numbers, but there is a shortage of staff to keep the community hospitals open. A recent example is Aboyne hospital. What is going wrong, and what can NHS Grampian do to improve the current situation? We know that, in rural areas, there are issues with falls, which will create further pressure on local units.

Dr Coldwells: That is a good area for us to explore to try to understand what is causing the challenge and, as you have asked, what we can do about it. First, it draws on lots of the narrative that I hope that I have given, and which Jeff Ace has definitely given, about rural areas. To use your example, Aboyne hospital is in a rural area outside Aberdeen and so draws on a population to work there that is different from the one that a hospital in the city centre draws on.

One of the things that we learned hugely about through the pandemic was deploying people from one area to another. We had reasonable scope to do that at the start, because we stepped down all sorts of services. The list of critical services was

quite small in episode 1. By episode 4—the omicron variant—the list of critical services was pretty much everything. Because of the postponement of services over a period, things had to be kept going.

The reason for restating that is that, when it comes to your example, our scope to deploy people who have the right skills from one place to another is almost non-existent. For example, the nurses who can work in a ward environment to support the population in Aboyne or Banchory or in general medicine in ARI are a very finite group. Our scope for the deployment of people between areas is very small.

The solution is not immediate. That is challenging. It is about how we do what Jeff Ace was saying in the previous answer: how we get the right staff numbers, so that we have resilience across the piece, as it was framed in the original question, and how we create the resilient staff group that can do it.

We are exploring whether we can have teams that are there to support other teams as they do it rather than it being done through the 24-hour planning and deployment of people. It is important to remember that staff hate being deployed from one patch to another. Being moved to another team with people they do not know without good planning or an induction has a negative impact on people's wellbeing and resilience. We are trying to plan and make that terrible side of deployment better, but it is really unpopular and has a negative effect on wellbeing.

You framed an on-going challenge, and I do not have a magic bullet for it, but those are all the things that we are worrying away at to try and improve so that we get resilient services across all our areas.

The Convener: Sandesh Gulhane has a question on this topic.

Sandesh Gulhane: As a GP, I know the troubles that we have with recruiting GPs, especially in rural areas, which is why I want to direct my question to Dr Coldwells. We heard about MDTs in the previous part of the meeting. When they are there, they are very good. In fact, I would suggest that there are a number of occasions on which it is better to see a member of the MDT than it is to see a GP, but patients feel as though they are being fobbed off. They do not feel that they are being seen by someone in primary care. What can you do to ensure that we take patients with us, and how can you improve messaging, because it is not getting out to the public?

Dr Coldwells: I will make two comments. The first is that public confidence in general practice is challenged at the moment, as you described. One of Aberdeenshire's MDTs, hospital at home, has been incredibly successful. That MDT works to identify people who are at risk of deterioration and could potentially require admission, and it wraps around them with an individual response that changes the trajectory of their illness. That has been extremely well evaluated and has had positive impacts in terms of outcomes and the inputs that patients have had as a consequence of the MDT. The patient is not present at that MDT; it does the planning.

The second thing that relates to rural populations is that we have a GP in a role who is trying to look at the sustainability of general practice and how we support it and create recruitment practice that is better in the longer term. That challenge has been on-going in Moray and Aberdeenshire for a long time.

We had a big programme to try and move away from 2C practices to independent practices, because they seem to give a different dynamic. That was very successful for a number of years building up to the pandemic. Independent practices create a different ownership and relationship in the community.

We all collectively need to work on the longer-term issue of gaining public confidence in the approach—be that from a political, local board or health and social care partnership level—so that everyone is transmitting and giving the same messages and having the same interactions with people as they come into contact with the system. We should take them on a journey of the positive benefits that we can have by working the system differently.

The Convener: We have a couple of questions on delayed discharges. The first is from Carol Mochan.

Carol Mochan: It is fair to say that we have discussed delayed discharges over many years, and we acknowledge that things continue to be bad and are possibly worse than they were before. The witnesses on the previous panel and the current one have mentioned how important delayed discharge is in resolving some of the issues.

You have talked about recruitment of staff, staff pay, intermediate beds, the role that AHPs can have and, of course, the pay, terms and conditions and recruitment of social care staff. What support do you need from the Scottish Government to move forward? There is a lot of urgency, but it does not always feel as though we are moving forward at pace with any of the ideas from you and the staff about Government support.

Jeff Ace: That issue is absolutely key. We have talked about A and E waiting times, elective care and general occupancy. You could argue that the

answer to almost all those issues would be to increase social care capacity to allow us to flow patients back to their homes. Late discharges are only a fraction of that gap in social care capacity. In any system, that is a far smaller number than the number of people who are at home and are not getting the full package of care that keeps them securely and safely at home. The demand gap there is bigger than the one that we are seeing in delayed discharges. It is an enormous problem—for me, locally, to get back on an even keel would require 100 full-time equivalent staff in social care providing that seven-days-a-week service.

The Scottish Government is well sighted on the matter. It has been working with boards on their capacity plans and with partnerships on what we are doing to address the issue; however, it is extraordinarily difficult. It is very hard to get rapid solutions to the questions about terms and conditions, who employs people and how we get that capacity by making the area look attractive to people so that they move into it. We have been looking at overseas recruitment, almost as a last-resort solution. We will see how successful we can be in bringing people from outside the European Union into working in social care, just as we have been doing with nursing staff.

In relation to the current model, I am also thoughtful about the issue of how much of the capacity can sustainably be provided by the private sector and how much we will have to step in and become an employer of significant additional social care capacity through our partnership. That approach is not a magic bullet; it generally comes at a greater cost. We have talked about our long-term financial problems before, so we have to find a way to model it successfully.

Given the way in which the labour market is moving, particularly in rural areas, the model of relatively small-scale private providers being able to staff themselves up and remain resilient and reliable might in the future become a smaller part of provision than the council, the partnership or the health board employing individuals and giving them a career pathway through our services. Again, it is not a magic bullet, it is not quick and it is certainly not easily achieved within our current cost envelopes.

Dr Armstrong: For patients who are ready to go home from hospital—I like that term better—there is a series of factors, and we have a development plan for HSCPs to really push forward. It is about getting a patient as soon as they are ready to go home, not only because the hospital needs the bed but because the longer a patient sits in a bed or a chair, the more muscle mass they lose. They can go from being able to transfer from the bed to the toilet, or being able to go to the fridge in their home, to becoming really incapacitated.

Although the acute sector does extremely well in trying to care for those patients, being in the middle of a busy acute receiving ward with lots of patients moving in and out is not an ideal place. We need to prevent people from needing long-term care to begin with, which is about having better rehabilitation services, with rehab teams going into hospital and taking the patient home so that they are surrounded by their neighbours and have a decent chance of regaining the muscle function that they have lost.

12:15

The second issue is more controversial. In Glasgow, about a third of our patients are adults with incapacity, and there is legislation that relates to their care that can be changed only by Parliament. I mention that because many of those patients would do better in an intermediate care facility while they wait for their choice of nursing home or whatever to become available. I have had relatives in excellent nursing homes that have a range of activities, on-site hairdressers and people who deal with the residents as if they are in their own homes, which is not what happens on an acute ward. Unfortunately, we cannot move those patients, and there is a lot of delay. Those patients stay in longer than any other patients, they need legal processes to be gone through in relation to setting up power of attorney and so on. All of those things can build in long delays.

All doctors, nurses, managers and other members of the clinical staff are trying to do the best for each individual, and I am not sure that the legislation that says that those individuals must be kept in an acute site is helpful for us or for the patients. Further, as has been discussed today, all that goes back to the situation at the patient's front door and to them waiting in an ambulance for three or four hours while we try to get them into a hospital.

There needs to be a debate across parties about what we are doing with such patients and how to best deal with them in a way that protects everybody's rights and gives the best clinical outcome for the patients. I am talking not only about people waiting to get into hospital but about ensuring that the environment that they go into is a decent one in which people get them up each day and they can do things such as walk to the toilet and so on while we plan their onward journeys.

At the moment, a lot of that is done in the acute sector, and that approach takes up hundreds of bed days, during which time we cannot access those beds, which are fully staffed with acute consultants and nurses and would be better used

by patients who are sitting in the emergency department. The patients who are sitting in those beds would be far better off in a different facility while we sort out things such as power of attorney.

I know that that would be difficult, but you asked what could be done, and that is one suggestion that I would make.

The Convener: That is interesting. Could you clarify whether the issue legislatively is around power of attorney?

Dr Armstrong: You need to have a power of attorney in place, or seek it if it is not in place. That is why you see signs in the Glasgow subway telling people to sort out their power of attorney. Legislative change would be needed—I am not a legal expert and the legislation is complex—to ensure that people could be moved into intermediate care facilities. At the moment, a lot of delay is built into the process. The HSCPs are more expert in that regard than I am. Some thought is needed about what happens when someone who is medically fit for discharge does not have a care home that they want to go to. Do they stay in the acute sector, which is what currently happens, or can they be moved somewhere else?

I have spoken to nurses who are dealing with those situations, and, as I said, they say that, no matter what, they want to build in the best outcome for the patients. At the moment, the patients are not best served by the arrangements that are in place.

The Convener: Thank you for clarifying that. We might want to look into that in a bit more detail.

I invite Dr Coldwells to comment, after which we will take one final question from Tess White, but we must then move on to our next item.

Dr Coldwells: I will be quick. I have nothing to add to Dr Armstrong's comprehensive response on the issue of delayed discharge.

One thing that I think that the Scottish Government could do would be to start a different discussion about ageing and old age in our society and how we think about it philosophically. I would guide everyone in the committee to read "Being Mortal" by Atul Gawande, which gives a nice consideration of ageing, how we consider it and not only how we medicalise it but how we healthcare-ise it, as it were. I think that a national conversation about that would be helpful. We will not fix the issue in this session of Parliament but, if we do not start the conversation, we will never fix the problem. I suspect that delayed discharge is such a pernicious issue that, if we do not start a different conversation alongside all the tangible actions that Jeff Ace and Jennifer Armstrong set out, we will still be having the conversation that we have been having today in 10 years' time.

The Convener: Thank you. Tess White will ask the final question before we let our panel go.

Tess White: We have been discussing winter planning. NHS Grampian is doing a primary care redesign pilot programme in Aberdeen city, which is about exploring doing things differently to move things on before we get to the winter planning stage. Dr Coldwells, do you have any comment on that?

Dr Coldwells: As we have heard, there is no magic bullet for any of this. We need to explore options and have schemes that allow us to try different ways of doing things in as many different aspects as possible. That is absolutely the right thing to do. Will the work that you mention fix the situation and make everything fine? Absolutely not. Will it contribute positively? I absolutely hope so, and I think that it will be really good. We need to ensure that we consider everything that can be done. There are a lot of small incremental changes that can be made; I do not think that anything will suddenly solve the problems in a miraculous manner.

The Convener: I thank all members of the panel, particularly for the ideas that you have put forward and for flagging up the things that you are doing to try to make a difference. You have given us a lot of food for thought, and I thank you for your time.

Subordinate Legislation

Food Information (Transitional Provisions) (Miscellaneous Amendments) (Scotland) Regulations 2022 (SSI 2022/265)

12:21

The Convener: The final item on our agenda is consideration of two negative instruments.

At its meeting on 20 September, the Delegated Powers and Law Reform Committee considered SSI 2022/265 and made no recommendations. The purpose of the instrument is to update the list of home grounds for Scottish football clubs for the purposes of schedule 1 of the Sports Grounds and Sporting Events (Designation) (Scotland) Order 2014, as amended in 2022. The changes are required in light of promotions to and relegation from the Scottish football pyramid and to ensure consistency of approach over the application of the alcohol and other controls framework that is set out in the Criminal Law (Consolidation) (Scotland) Act 1995. Part II of the act imposes certain restrictions on the sale and consumption of alcohol at designated grounds for designated sporting events.

No motion to annul has been lodged in relation to the instrument. As members have no comments, do we agree that the committee does not make any recommendations in relation to this negative instrument?

Members *indicated agreement.*

Sports Grounds and Sporting Events (Designation) (Scotland) Amendment (No 2) Order 2022 (SSI 2022/263)

The Convener: The Delegated Powers and Law Reform Committee considered SSI 2022/263 at its meeting on 20 September and agreed to draw the instrument to the attention of the Parliament on reporting ground (j), for failure to comply with the laying requirements in section 28(2) of the Interpretation and Legislative Reform (Scotland) Act 2010. The committee also reported that it was content with the explanations that the Scottish Government provided for failure to comply with the laying requirements.

The purpose of the instrument is to make amendments to existing transitional provisions contained in subordinate legislation and in retained European Union legislation that relate to various food labelling requirements. The amendments, which apply only in Scotland, extend previous transitional arrangements that were due to expire at the end of September 2022 so that they continue to apply until the end of 2023.

No motion to annul has been lodged in relation to the instrument. As members have no comments, do we agree that the committee does not make any recommendations in relation to this negative instrument?

Members *indicated agreement.*

The Convener: At our next meeting, we will take evidence on the recently published independent review of racism in Scottish cricket and from representatives of integration joint boards on their experiences to date of health and social care integration in Scotland.

Tess White: Before we move into private session, could we mention the inquiry into female participation in sport?

The Convener: That will be dealt with when we move into private session.

12:24

Meeting continued in private until 12:46.

This is the final edition of the *Official Report* of this meeting. It is part of the Scottish Parliament *Official Report* archive and has been sent for legal deposit.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba