OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 17 January 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 17 January 2023

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

2nd Meeting 2023, 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:

Susan Gallacher (Scottish Government)
Professor Sir Lewis Ritchie (Scottish Government Adviser)
Dr Gregor Smith (Scottish Government)
Humza Yousaf (Cabinet Secretary for Health and Social Care)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 17 January 2023

[The Convener opened the meeting at 09:45]

Decision on Taking Business in Private

The Deputy Convener (Paul O'Kane): Good morning, everyone, and welcome to the second meeting in 2023 of the Health, Social Care and Sport Committee. The convener, Gillian Martin, has sent apologies for being unable to attend today's meeting. The first item on our agenda is to decide whether to take item 5 in private. Do members agree to do so?

Members *indicated agreement.*

Petitions

Rural Scotland (Healthcare Needs) (PE1845)

Rural Healthcare (Recruitment and Training) (PE1890)

Women's Health Services (Caithness and Sutherland) (PE1924)

The Deputy Convener: Agenda item 2 is an oral evidence session with the Cabinet Secretary for Health and Social Care on three public petitions—PE1845, PE1890 and PE1924. All three petitions relate to rural healthcare.

I welcome from the Scottish Government Humza Yousaf, who is the Cabinet Secretary for Health and Social Care; Susan Gallacher, who is deputy director of primary care strategy and capability; Sir Lewis Ritchie, who is a professional advisor; and Dr Gregor Smith, who is the chief medical officer. The cabinet secretary will make an opening statement, then we will move to questions.

The Cabinet Secretary for Health and Social Care (Humza Yousaf): Thank you so much, convener. I thank you all for being so accommodating of my time; I am grateful to the committee for shifting this meeting to a slightly later time in order to help me with childcare issues. I am also grateful for the opportunity to be here today to respond to the committee on questions relating to the public petitions that the deputy convener mentioned.

Let me begin, as I did last week, by reiterating the fact that we are currently experiencing extreme pressures in our health services. This is, by any estimation, the most challenging winter that the national health service in Scotland and the United Kingdom has ever faced. Our NHS and its committed workforce face a perfect storm of intense pressures that are leading to difficulty, disruption and delay across the service—including in remote and rural communities, which too often face their own significant challenges. I suspect that we will touch on many of those issues during today's discussion.

As I outlined last week, we have advised health boards to exercise their own judgment in relation to their locality and what action is necessary to overcome or, at least, to mitigate some of the challenges that they are experiencing. I am aware of the challenges that rural Scotland faces in healthcare, having visited all our health boards and spent a significant amount of time in boards that cover remote, rural and island communities. I am determined to ensure that our remote and rural

areas are not left behind as we continue to invest in and reform our health and social care systems.

I expect NHS boards that service remote and rural areas to take account of the particular needs of their communities, to ensure that services are delivered flexibly and innovatively, to recognise the concerns of local populations and to take account of the significant geographical challenges. A blanket approach for a country that is as geographically diverse as ours is simply not appropriate.

Front-line workers are the foundation of our health and social care services. We have committed to growing that foundation and overall staffing levels have increased by almost 3,000 permanent whole-time-equivalent roles during the past year. That builds on our strong track record of delivering 10 years of consecutive growth, with almost 30,000 more whole-time equivalent staff working in the NHS now than there were in 2006; the actual figure is around about 28,900.

We are making nearly £8 million of funding available to NHS boards to support recruitment of up to 750 nurses, midwives and allied health professionals from overseas this winter. That will, of course, include boards that include remote and rural localities.

We are creating opportunities for an initial 250 band 4 assistant practitioners across acute services, primary care and mental health. We continue to expand the number of trainee doctor posts in line with medical workforce modelling. Since 2014, 725 additional training posts have been created, including 152 that I recently agreed would be recruited in 2023. I am sure that the committee will discuss this, but we know the importance of training posts being available in remote and rural health boards.

I recognise that general practitioners in remote and rural areas also have distinct challenges. That is why we have invested £7 million of funding since 2019 to take forward a range of initiatives to support rural general practice. Those include support for recruitment and retention: a “golden hello” scheme to attract new rural GPs; a £20,000 bursary to recruit and retain GP trainees in hard-to-fill locations; Scotland’s first graduate entry medical programme—ScotGEM—which provides a graduate entry medical degree that has a real focus; and a pilot scheme to recruit experienced GPs to provide support for rural practices. So far, 52 students have graduated from the ScotGEM programme—in fact, I think that the CMO was at that graduation—which has allowed them to progress to foundation year 1 posts.

We are also supporting a recruitment campaign called “Rediscover the joy of general practice”—many committee members will have heard of it—which aims to recruit experienced GPs to provide support for remote and rural practices. I will be happy, as we get into the meeting, to give some detail on how that programme has assisted. NHS Education for Scotland has also developed for doctors a credential in remote and rural healthcare that recognises the unique skills that are required to work in those challenging regions and provides a route for upskilling in those environments.

We are working closely with NHS Education for Scotland on scoping a national centre for excellence for remote and rural health and social care. That is another piece of work that Sir Lewis Ritchie was not just involved in but led. I am grateful for all the work that has been done in that regard. That centre will have an initial focus on primary care, although I imagine that it will be of interest to people from right across health and social care. It will be a resource that boards and health and social care partnerships will be able to use in support of their responsibilities in providing rural health and social care. Our aim is that the centre will identify, celebrate and—importantly—pull together the many examples of innovative work that are already going on, and promote excellence to address the long-standing issues, particularly recruitment and retention, in remote and rural areas.

We remain committed to growing our nursing workforce in remote and rural areas and we look forward to welcoming new pre-registration nurses to the University of the Highlands and Islands in the 2023-24 academic year. Since the programme was established in 2017, we have seen a fantastic increase of 34 per cent in intake.

Although we are committed to investing in reforming the NHS and social care systems nationally, we are fully aware of the challenges of rural healthcare and are responding to them.

Women’s health is a key priority for the Government, which is why Scotland was the first country in the UK to publish a women’s health plan in August 2021. Our ambition is to have a Scotland where health outcomes are equitable across the population, so that all women, regardless of where they live, enjoy the best possible health throughout their lives. There has been substantial progress since publication of the plan. There is now a specialist menopause service in every mainland health board and a buddy support system in place for island health boards. We have initiated new research on endometriosis, launched a new women’s health platform on NHS Inform and increased access to bridging contraception in community pharmacies. However, of course, there is still much to do. I hope that those are important and welcome first steps.

Although a formal review of NHS Highland’s gynaecology services is under way, the board has

set up additional capacity for outpatient and theatre treatment. That will provide much-needed capacity across Caithness general hospital, Belford general hospital, Lawson memorial hospital and Raigmore hospital.

I thank our exceptional health and social care staff, who make an incredible contribution to keeping us safe, especially under the current challenging conditions and especially where challenges can be exacerbated by remote and rural geography. I am also grateful to the petitioners for taking the time to bring the petitions to our Parliament.

I am happy to take questions on those matters and any others that members wish to ask.

The Deputy Convener: Thank you. I am very grateful to the cabinet secretary for his opening statement, which has helped to set the scene for our questions. I will begin with broad questions before we move to questions from colleagues.

The petitioners have outlined the various challenges with regard to geography, access to services and availability of staff, and you have touched on much of that, cabinet secretary. Given the wider structural challenges in relation to the way that the NHS is set up and operates in many of the relevant communities, has any thinking been done about structures and how the NHS operates at board level in those communities? Do we need to look at how boards operate? Do we need to consider devolving more power to local communities? Have there been conversations about that? A great deal of what the petitioners have asked for is about decision making being more localised. Do you want to comment on that?

Humza Yousaf: That is an excellent question. I often go to remote and rural health boards. Let us take the example of NHS Highland, which probably covers the largest geographical area and which—as you know, convener—covers Argyll and Bute as well as the north Highland area. People in Argyll and Bute might say that although there are similarities there with what other parts of NHS Highland are facing, there are also unique challenges, given the area's geography, particularly on the islands. Therefore, yes—a conversation is absolutely needed about further devolving decision making.

That is why, when I visited the Caithness Health Action Team, for example, which is the campaign group on Caithness hospitals, it came across very strongly that the group feels that there is a disconnect between the community in Caithness and what it says comes from the health board at management level. That is what it communicated to me, so I took that back to the board. I am pleased to say that there are now regular scheduled meetings between CHAT and the health board.

There absolutely should be devolution, as far as that is possible for a health board. Even if there is no direct decision making, it is certainly important to have engagement at local level. That is important for urban areas, but I would say that it is even more important for remote, rural and islands health boards.

I might draw a line under that at this point, because we are not looking at a wholesale structural review of health boards. Given all the other pressures that we are facing, we are also not talking about breaking up health boards into smaller health boards—certainly not at this stage. We have a structure in place, and disrupting that in its entirety now would take a lot of focus away from the significant challenges that we face.

Having said all that, I note that the National Care Service (Scotland) Bill is going through Parliament, and I know that every member around this committee table knows that healthcare and social care are integrated, so there is therefore certainly a conversation to be had about the interaction between healthcare and social care—under the current system, but certainly with a view to a national care service coming into play.

The Deputy Convener: I will move to a question on something that you have referenced—the work that is being done on a national centre for remote and rural healthcare. As a committee, we are keen to understand how success will be measured in that innovation. It would be useful to have an update on the progress on developing that centre. Sir Lewis Ritchie might want to comment, but I will come to the cabinet secretary first.

10:00

Humza Yousaf: I will bring in Sir Lewis Ritchie shortly. It is a good question. We know that multiple good innovations are taking place across a number of health boards in remote and rural Scotland. Doing that work more collaboratively might bring a better return for those health boards. Essentially, it could be really helpful for the centre for excellence to multiply those innovative practices across remote and rural Scotland. Sir Lewis might be able to talk more about that, as he was deeply involved in the genesis of the idea for a centre for excellence, which is about sharing effective practice, data and evidence, and supporting boards to deliver a stronger collaborative response to concerns.

The biggest concern by far that I have heard from health boards in remote and rural locations is around recruitment and retention of the workforce. That tends to be the biggest challenge, and the

centre for excellence can help in that regard. NES has agreed to host the centre, which makes sense, given its education and training remit. It is a natural fit.

Understandably, the big question is about funding. As you know, convener, we are in discussions about the 2023-24 budget. I will not pre-empt the conclusion of that budget process, but I have asked for a proposal on how much the centre would require in 2023-24 to make progress. I am still waiting for that information to come back from NES; I expect it shortly and will consider the proposal with an open mind.

I will pass over to Sir Lewis, who has been deeply involved in work on the centre.

Professor Sir Lewis Ritchie (Scottish Government Adviser): I will frame my initial response this way. The cabinet secretary mentioned the enormousness of the challenges in remote and rural areas. I am reminded that although 17 per cent of the Scottish population stay in remote and rural areas, the land mass of those areas is about 98 per cent of Scotland, which clearly brings unique challenges for service delivery, retention and recruitment of staff and fulfilment of equitable care across the country.

The centre was born out of one of 12 recommendations that we made to the Scottish Government on how to improve delivery of the 2018 general practitioner contract in remote and rural areas. That recommendation included consideration of the future of contractual arrangements and how they could be modified for the better. It looked at recruitment and retention, and at both physical infrastructure and delivery infrastructure, which is clearly important—one of our recommendations in that regard was that considerable scope exists for digital innovation.

I have three summary words for the centre itself: it should be a centre of excellence for education, innovation, and evaluation. Too often in the past we have implemented models—not in one of the remote and rural areas, but across Scotland—in which we had not done the due diligence of evaluating the benefits and the costs. If we get the centre in its best position, I expect it not only to benefit remote and rural communities but to have an international profile so that others can learn from us and the good things that we do in Scotland.

The Deputy Convener: There are some supplementary questions.

Sandesh Gulhane (Glasgow) (Con): I have heard a lot about recruitment and retention, and staff, and those issues are all very important when it comes to our rural areas. However, I would like to know the impact of the £65 million cut to the GP budget, and how it affects primary care in rural areas, which are already struggling more than places in the central belt.

Humza Yousaf: It is difficult to evaluate because we are in the midst of the current financial year. Dr Gulhane will know that we took a very difficult decision in the emergency budget review, largely because the UK Government's mismanagement of the economy meant that my budget was worth £650 million less than when it was set last December. On top of that, we have proposed a record pay deal of 7.5 per cent, which is far greater than any other country in the UK has suggested for its NHS staff and means that, currently, Scotland is the only country that is not experiencing nurses or any other NHS strikes this winter. We had to make some really difficult decisions; partly because of decisions that we have taken around the workforce and partly because, due to mismanagement of the economy, £400 million had to be reprofiled.

There are no easy decisions—mental health, primary care and social care are not areas where any health secretary in the world would choose to look to make savings. The impact of those savings, whether they are in primary care, social care or mental health, will only be realised as we come towards the end of the financial year. It is fair to say that we have been working closely with our GP services and everyone in primary care to see what we can do to try to mitigate the impact.

I suspect that one of the main areas of concern—this was highlighted by the British Medical Association in response to the reprofiling of funds—relates to the sustainability of funding. In the next financial year, 2023-24, I am keen to ensure that we do not lose focus on the increase that we have seen in multidisciplinary team staffing in all GP practices, both urban and rural. Recruiting more multidisciplinary staff, including advanced nurse practitioners, physiotherapists and pharmacists has been a significant benefit for remote, rural GP practices in spreading that workload in areas where it is more difficult to recruit GPs.

All of that can make a significant difference. However, I will not pretend that a cut in primary care of the scale that we have made will not have an impact. We need to evaluate some of that impact and ensure that we mitigate it as best we can in 2023-24.

Sandesh Gulhane: In that answer, we are also missing the fact that vacancies are on an upward trend. If we look at AHP vacancies, we can see that there are 1,252 whole-time equivalents required. If we look at medical and dental, we see a requirement for 392 WTEs and nursing and midwifery require 6,319 WTEs. That was an upward trend from before the cuts. My real concern is that we will see rural and deprived

areas really struggle when it comes to primary care services. That will affect people in those areas more than it will affect people in the central belt. I am not hearing a solution that will help.

Humza Yousaf: Let me try to give a few solutions, if I can. Dr Gulhane is right, workforce recruitment, plus the retention of that workforce is exceptionally important. There are a few things that we are trying to do. First and foremost, we have a good record in recruitment and staffing. I referenced some of that in my opening statement. However, I do not disagree with Sandesh Gulhane that the vacancies are far too high. I look at the vacancy rates around nursing and midwifery in particular and they are clearly far too high. We have to try to resolve that.

I have often said in the chamber that we must consider recruitment and retention as separate workstreams, although they are interlinked. There is no point filling the leaky bucket; our recruitment record is good, we must ensure that our retention record is just as good. We start from a strong position, with that increase of staffing of almost 28,900 since 2006 and our having more GPs per head than anywhere else in the UK and more nurses per head than other parts of the UK.

Dr Gulhane talked about solutions. What are we trying to do about it? I will come to retention shortly, but I think about there being a three-pronged approach to recruitment. The first prong is the pipeline: we are ensuring that our pipeline of graduates coming through the system will match our demand for the future. For example, we have made commitments for the medical workforce and fulfilling the commitments to increase them by 100 per annum over the course of the parliamentary session—so, 500 by the end of the session. So far, we are not just meeting, but are exceeding that target—there have been 10 consecutive years of growth, as I mentioned.

The second prong is domestic recruitment, and by domestic I mean right across the UK. We have a very proactive campaign under way to recruit GPs, which has a focus on recruiting to remote and rural Scotland from other parts of the UK. I make no apologies for that, because remote and rural parts of Scotland are very attractive places to work.

The third prong is the international recruitment piece. You ask about solutions; there is £8 million to try to recruit 750 nurses, midwives and AHPs, but that is not a panacea. I will not suggest to you that international recruitment will resolve all the challenges that we face around the workforce, but it can make a difference as part of that three-pronged strategy. I engage with remote and rural health boards, and they believe that we can get more advantage than we currently get from international recruitment, particularly in remote and rural areas.

We are doing a lot on retention. I attended a nursing round table with the Royal College of Nursing, and a couple of members who are at this table were there. Gillian Mackay was certainly there, and she will remember a nurse's comments about retiring and being rehired. The inflexibility that existed there meant that she was going to leave the health service altogether. That is a huge loss, because she had well over three decades of experience. That was fed back to the chief nursing officer who, I am glad, working with the RCN and others, has in place an updated retire-and-return policy that has been welcomed by much of the workforce.

The BMA, which is another trade union or professional body, has called for a direct pension scheme. It has called for an employer pension contribution recycling scheme to be developed to deal with some of the pensions disincentives that exist in the system. A direct scheme was very much in our gift, so we have devolved that to health boards, and direct schemes have been live in health boards across the country since the end of December. More can be done on pensions, and I welcome what the UK Government has done thus far, but the BMA is calling for it to go even further, and we support that call.

I have taken up a fair bit of time on that answer, but I could speak to more that we are doing on recruitment and retention. Much of it is geared towards helping our remote and rural health boards.

Emma Harper (South Scotland) (SNP): Cabinet secretary, you will be aware that I have written to you on a few occasions about specific issues in remote and rural Dumfries and Galloway, such as those in Stranraer. I appreciate your responses, so thank you for those.

I am interested in the centre for excellence for remote and rural health and social care. Sir Lewis talked about education, innovation and collaboration. I am interested in whether the centre will have a role to advocate for people in remote and rural areas, because those folk cannae access the self-help groups and the people who are in urban areas. I know that people use Zoom and so on to engage, so is there a place in the centre for excellence for advocacy to be supported or delivered? I know that Australia has a National Rural Health Commissioner. I am interested in those aspects of the centre for excellence.

Sir Lewis Ritchie: If I may, I will reflect on a comment that the cabinet secretary made about the "Rediscover the joy of general practice" scheme. It has promoted 65 GP vacancies in

Scotland that have been temporarily filled. I wanted to flag that in passing.

The exact nature of the centre for excellence is still being scoped out, and that work is being done by NHS Education for Scotland. My personal view is that the centre would not have a particular advocacy role; it would be involved in educational development, and as we said earlier, in innovation and evaluation. Those would be its prime concerns.

10:15

You mentioned the National Rural Health Commissioner for Australia. I flagged that role to the Citizen Participation and Public Petitions Committee as part of my written evidence in response to its request for my views on the petition that it was considering. That post was established in 2017, and the first commissioner published a report in 2020. The commissioner plays an advocacy role in relation to service development and educational development. Therefore, a rural health commissioner, if considered, might be an office that could advocate for remote and rural matters.

Humza Yousaf: I am happy to add that the Government is in agreement that the centre of excellence probably would not have an advocacy role, given that that sits with NES. I do not think that an advocacy role would quite fit in with the original thinking behind the centre.

The idea of having a rural health commissioner has merit. We have been focused on what the centre's core purpose will be rather than on considering whether to have a commissioner. As Sir Lewis said, there is such a role in a number of other countries, so the idea is certainly worthy of consideration. However, the primary focus must be on getting the centre for excellence up and running.

Emma Harper: I am thinking about the need for an advocacy role because we have been looking at cancer pathways for more than 20 years. People from Stranraer, for example, go to Edinburgh for radiotherapy. That trip is 140 miles compared with 87.2 miles to go to Glasgow. That is an issue if we want to support people getting their care closer to home.

People in Dumfries and Galloway go to the South East Scotland Cancer Network, but nowhere in that region is in the south-east of Scotland. Are there opportunities to look at the cancer pathways to ensure that people in Stranraer go to Glasgow instead of travelling 140 miles to Edinburgh?

Humza Yousaf: You have raised that valid question before. You will have to forgive me, but I do not have the most up-to-date position in front of me. I entirely see the logic that you are deploying in relation to Stranraer and your feeling that it would make far more sense for that area to be part of the west of Scotland cancer pathway.

If you do not mind, I will take a look at the latest position. I had raised the matter with the health boards that are involved and I remember the response at the time being that many patients could travel from Stranraer to Glasgow. However, if that is not happening—if that is not people's experience—I will want to find out why that is the case. If you are okay with that, I will come back to you—perhaps through the convener—in writing on that specific point.

More generally, as I said, the issue of a rural health commissioner is worthy of exploration. However, based on the volume of correspondence that I get in my inbox, even if we were to establish a commissioner, any expectation on them to advocate on behalf of every patient in relation to every challenge to and issue that we have with the health service would be very difficult to meet.

Patient rights are embedded in statute and guidance. We also have in place robust procedures to deal with complaints and so on. We probably need to take a bit of time before we consider further whether there could be a commissioner, or an organisation or individual, who will advocate on patients' behalf.

Emma Harper: When Jeane Freeman was the Cabinet Secretary for Health and Sport, she advocated for people being offered choice. People might want to go to Edinburgh for radiotherapy if they have family there and they can stay overnight.

There are on-going challenges in supporting patients and managing expectations. I understand that people must sometimes go to other centres because there is no ability to deliver radiotherapy locally—the new hospital in Dumfries does not offer that treatment, for example.

I would appreciate some follow-up information, so thank you for your offer.

Humza Yousaf: I will get you the latest position. Of course, choice is good only if people are offered it.

The Deputy Convener: Thank you. That is very helpful.

We move to questions from Carol Mochan on the wider involvement of service users.

Carol Mochan (South Scotland) (Lab): Good morning, and thanks for coming to the meeting.

I am very interested in exploring the experiences of people in remote and rural areas, and how they interact with services. The

Government often repeats its commitment to and engagement with service users and people with lived experience, but there is a sense from the petition and from other action groups that that engagement does not happen particularly well. Will the cabinet secretary speak a little about how he thinks that that is going? I know that there is a responsibility to do that and that Healthcare Improvement Scotland monitors that. However, how does the cabinet secretary feel that the engagement in relation to the petition has gone in remote and rural areas?

Humza Yousaf: I am always of the opinion that we can never have too much engagement, and I think that engagement and visibility are positive. It can be tricky. For example, last week, I had to cancel a meeting with the fantastic women's hub in north Highland, much to its annoyance—understandably so—because of certain pressures in the parliamentary schedule. There will always be times when engagement can end up being disrupted for understandable reasons.

However, what frustrates me slightly—I will not mention any health board, as all health boards need to be cognisant of this issue—is that it can often feel as though there is a disconnect between the health board management, and health services and provision locally on the ground. My instruction to all the health board chairs, chief executives and senior management is that they should be visible and that they should ensure that engagement happens regularly. There should be not just engagement. What can be done to make people feel that they are being heard, and what proactive action can be taken to demonstrate that we are listening? Although we will not be able to do everything that everybody wants—that is simply the nature of what we deal with—I would say that the engagement has gone well, but there is certainly more to do.

I also encourage boards to make the best use of technology. I know that it is not always possible to travel around the vast expanse of the NHS Highland area, for example, and that it is not always possible to get everywhere all the time in Orkney, Shetland and other islands, so one of my instructions is to make the best use of technology.

Dr Gregor Smith (Scottish Government): There are signs of some areas beginning to do that really well. I will give the example of the recent opening of the community hospital in Aviemore and the community engagement around that. The community was involved in the planning of how that community hospital would work and the services that would operate from it. That continued thereafter with the service providers that operate from it. The hospital has become what we would refer to as an anchor institution in the community—a place in which people can begin to coalesce, discuss their ideas, and consider how to involve wider community engagement. That is a model for the future that we need to begin to exploit more and more, particularly as we bring on some of the wonderful capital projects. We can begin to have that acting as the fulcrum for the engagement that has been spoken about. Aviemore is a very good example in that context.

Carol Mochan: It is only fair to ask the cabinet secretary directly about the petitioners' request for an agency for engagement with service users to find out exactly what his view on that is. I was very interested in the discussion about a rural commissioner. It might be useful to discuss that with the petitioners, as well. What is your view on an agency?

Humza Yousaf: We do not create new agencies, organisations and institutions lightly. That is partly because we do not want to clutter a landscape that you could argue already has a fair bit of bureaucracy around it, but also because there are financial resource implications to which we have to be alive and alert, which we all are, particularly given the current pressures.

I am invested in and committed to the centre for excellence, which we have already spoken about. That can help us with some of the challenges in remote and rural Scotland. I do not think that it would have an advocacy role. I do not intend to create an agency that advocates for patients, although we have committed to a variety of commissioners already in this parliamentary session. Carol Mochan will know the work that we are doing on patient safety and patient safety commissioners.

I know that it will be a disappointment to the petitioners but, at this stage, I am not looking to create a new agency that works on advocacy. However, the centre for excellence can play a critical role in helping us with remote and rural healthcare.

Sir Lewis Ritchie: I will come in on the back of the cabinet secretary's and the CMO's comments.

I, too, am an advocate of public involvement in service provision. The people who receive services are entitled to shape them. For them to do that, you need to consult and meet those who you want to shape services.

I have been privileged to do a number of reviews and, always, as part of the process of those reviews, I would have a number of meetings not only with the people who provide the services—clinical colleagues and support colleagues, who are sometimes lost sight of—but with the public. I am a firm believer not only in advocacy at individual patient and public level but in what has been described as co-production, which is those who receive the service working

directly with those who provide it to make better services in localities throughout Scotland.

The Deputy Convener: We move to further questions about the accessibility of services and on regional and national planning. Sandesh Gulhane will lead on this section.

Sandesh Gulhane: I have a number of questions to ask, cabinet secretary, but, first, I will pick up on something that you said to me earlier. You mentioned that your budget was worth £650 million less. You have said that in the media and in the chamber. How did you arrive at that figure? Are you happy and confident that it is correct?

Humza Yousaf: Yes. It is given to me by some of the financial experts and analysts we have in the Scottish Government. They look at what the inflation level was when the budget was first set and what it was at the time we made that statement. Obviously, inflation fluctuates, but those figures were arrived at when inflation was at its peak. I am happy to provide more detail to Dr Gulhane if he wishes and to give him the full analysis and breakdown of that £650 million less that our budget is worth. I am confident in the figure.

Sandesh Gulhane: Have you ever personally driven the A96 between Elgin and Aberdeen?

Humza Yousaf: Yes.

Sandesh Gulhane: I have done it as well. I did it on a sunny day, but imagine that it is winter, cold and dark and that your pregnant partner is in the back of the car screaming because it is time to go to hospital because your baby is due. Is that a position that we want anyone to be in because the consultant-led maternity service at Dr Gray's hospital is no longer running? Is it safe? We have many times been told that people have given birth in laybys.

Humza Yousaf: It is certainly not a situation that I would want to find my wife in, and I would not want to be in that situation myself if I was driving my pregnant wife along the A96. I am sure that we will touch on Caithness, too. It would be the same for people there. Let us consider what the weather is like in Caithness now and has been over the past few days.

10:30

I would not want to be in that position. However, it is worth saying at this stage that there is not another local matter that I have spoken more about in the chamber—in ministerial statements or debates—than Dr Gray's hospital. Rightly, it gets significant attention from me, as cabinet secretary, and from the Government. I will not rehearse the latest position on it, because I think that Sandesh Gulhane was in the chamber during the last debate, and if not, he will certainly have apprised himself of the latest position.

The safety of women and their unborn children has been at the centre of our thinking on Dr Gray's hospital. We could not, in good conscience, have a consultant-led service tomorrow, because if we said that all pregnant women in Elgin and Moray should give birth in Dr Gray's from tomorrow, next month or later this year, we would be putting women and their unborn children at risk of very serious harm.

Part of the discussion on that can be understood if we look at what Ralph Roberts said in his report about Dr Gray's. He referenced "low risk" elective C-sections. I am very aware that I am talking to a doctor, who I suspect will have far more clinical expertise than anybody else at the table has, and who will therefore be the first to understand that a low-risk elective C-section can quickly turn into a high-risk elective C-section, as there is potential for bleeding or haemorrhaging and for blood transfusions and other such things to be needed. The facilities at Dr Gray's hospital would not allow for such issues to arise, so even what is termed as a low-risk C-section in Ralph Roberts's report requires significant investment in the facilities and the workforce.

As the member knows, NHS Grampian has recently come forward with a plan for the return of consultant-led maternity services sooner than was previously predicted. In the chamber, a number of people referenced a 10-year or seven-year timescale, but the member will know that the timescale that NHS Grampian proposes is far shorter than that—it goes just beyond the end of this parliamentary session, in 2026. That is positive, but I do not underestimate how much of a challenge it will be to get there, and that is why workforce and recruitment and retention issues will be at the core. Investment and capital infrastructure are not as difficult as recruitment and retention.

Forgive me—that was a long answer to a short question, but I do not feel that it would be safe if we instructed that all pregnant women in Moray should give birth at Dr Gray's hospital; it would not be safe for the women or for their unborn children, given the challenges around the workforce and facilities. The chief medical officer might want to add to that answer, given his clinical expertise.

Dr Smith: I just want to emphasise that final point about the assessment of the safety of the service that it would be possible to provide just now. From discussions that I have had with the medical director and others in NHS Grampian, I know that that the health board's intention is to move forward as quickly as possible with its plans, but it did a risk assessment on the environment of risk we find ourselves in when we practise

medicine and found that it could not offer a service that would pass that assessment.

Sandesh Gulhane: I have a question about accessibility of services. The Transvaginal Mesh Removal (Cost Reimbursement) (Scotland) Act 2022 was passed unanimously. What progress have we had for women in rural areas—also for those throughout the country, but the focus today is on rural areas—who want to get their service from Glasgow, somewhere else in the UK or the United States? Where are we in that process?

Humza Yousaf: The member might be aware that we have a debate later this afternoon on the mesh issue—indeed, he may be taking part. It is largely focused on hernia mesh, but I suspect that it will segue into the issue of transvaginal mesh, so I can give a further update after that, and if the member wishes for a written update, I am also happy to provide that.

The member will know that we now have contracts in place for other providers in England, such as the Spire Healthcare clinic and Dr Hashim, and the overseas contract with Dr Veronikis in the Missouri clinic is under way. I have to be careful about what I say, because we do not want to get into the territory of patient identification, but it is fair to say that patients have travelled to those providers, although I cannot tell you the locality—again, because of patient identification.

I had a meeting with a number of women who have been affected by the transvaginal mesh issue, some of whom were from remote areas, and they made a point of telling me that we could definitely improve the service for them. One woman from a remote rural health board—again, I will not say which one—told me that she was perplexed that she was offered a 9 am appointment with the complex mesh service in Glasgow. It made no sense me either that she was offered a 9 am appointment when she was travelling many hundreds of miles to get there. In some circumstances, as Sandesh Gulhane will know, the health board will pick up the costs for travel, but only in certain circumstances. Why make people go through that? They are willing to travel but do not want to have to leave the house at 6 am to make sure that they get to the appointment on time. I fed that back to the complex mesh service in Glasgow and I understand that that feedback is being taken on board.

To go back to Carol Mochan's point, I will regularly engage with women who have been affected by transvaginal mesh, as well as some of the campaign groups and, if that change is not being implemented on the ground, I would be pretty concerned. We can definitely make tweaks in that regard to support women who are affected in remote and rural health boards.

The Deputy Convener: We have a number of supplementary questions and we will start with one from Tess White.

Tess White (North East Scotland) (Con): Since June last year, I have repeatedly tried to ask the Scottish Government when a women's health champion will be appointed. The Minister for Public Health, Women's Health and Sport and even the First Minister have deployed every delaying tactic in the book, and the can is just being kicked down the road. The petition on the services in Caithness and Sutherland underscores why a women's health champion is so important to Scotland. Why is a women's health champion not a priority for the Scottish Government? Can you say today when an appointment will be made?

Humza Yousaf: We—the First Minister, Maree Todd and I—have tried to approach that issue with openness, honesty and transparency. I do not share Tess White's cynical view of the Government that we have been trying to kick the matter into the long grass or to kick the can down the road. That might be her characterisation, but that is certainly not the approach that we have taken.

First, we have always said that we want the right person to be appointed. That is important, because we envisage the women's health champion being in place for a long period, and we do not want to get the wrong person. As you can imagine, because of their calibre, the people who have applied for the position have many other commitments, so we have to be absolutely sure that they are able to provide the necessary time for that exceptionally important role. There is a discussion to be had about the time commitment that is involved and people's other commitments. Everybody who has applied and everybody whom we have interviewed for the role is of incredible stature, is incredibly busy, and has other commitments. We have to work around that and ensure that they understand our expectation of the role.

Secondly, although the role of the women's health champion is absolutely important, the fact that the champion has not yet been appointed does not hamper our progress on the women's health plan. I could give a range of initiatives that we have taken forward. As you know, the women's health plan contained 66 actions, and we have already progressed a range of them—I think that I have already referred to some of them. I could give members a list of a number of those actions, but I will not do so at this point. If you want that further information, I would be happy to write to the committee. I do not think that the lack of a

women's health champion hampers us from being able to make progress.

Thirdly, the direct answer to your question is that the Government hopes to make an announcement on the women's health champion within weeks as opposed to months. We are very close to doing so. As I have said, there are just some i's that need to be dotted and some t's that need to be crossed. I think that we will have an excellent women's health champion if we get things over the line and in place. The intention is to get things over the line in weeks as opposed to months.

Tess White: Thank you.

Emma Harper: My question is related to Sandesh Gulhane's questions about Caithness and Moray and Dr Gray's hospital. There is the same issue in Stranraer. I hate to go on about it, but women are delivering their babies at the side of the road. There are real recruitment challenges for Dumfries and Galloway in finding midwives for a midwife-led maternity unit at Galloway community hospital. I am not advocating that we start doing emergency caesarean sections—as a former operating room nurse, I have been there, taking babies out of people by crash section in a rush, so I am not advocating that we start doing that in Stranraer, for instance. I know that Maree Todd visited Stranraer in October last year to engage with the local Galloway community hospital action group and to visit the hospital.

The cabinet secretary does not have to respond to this today, but I know that there are real challenges in relation to midwifery-led units, and I am interested in getting an update on the work that is being done with NHS Dumfries and Galloway around maternity services being reinstated at Stranraer.

Humza Yousaf: I can provide a written update to Emma Harper on that specific issue.

We are very alive and alert to the issue of midwives in remote and rural Scotland. Emma Harper will know about the distance learning course that we are now running, which came on the back of engagement and discussions with rural and remote health boards.

The course for nurses to qualify as midwives is running for a second year at Edinburgh Napier University. My understanding is that the short midwifery programme allows students to fully qualify as midwives in just 20 months, so it is a really good course.

The percentage of nurses from remote and rural health boards who were enrolled on the distance learning course was 47 per cent, so almost half of the entire intake was from remote and rural health boards. That figure has now increased to almost two thirds—65 per cent of the students on the shortened midwifery course come from remote and rural health boards. Distance learning is an advantage for them because they can remain within their board.

We are doing a lot—that is just one example in relation to the nursing midwifery side of things. On Emma Harper's specific point, I will send a written update to the convener.

Gillian Mackay (Central Scotland) (Green): I think that the cabinet secretary shares my view that we should be trying to deliver services as locally as possible. He mentioned the Lawson memorial hospital in Golspie. I have family members who have had stints in that hospital. It is a brilliant facility, but the building is not the newest building in the world. How can we ensure that such buildings can keep up with the pace of the technology that is being delivered in some of our bigger hospitals in the central belt, where appropriate, and how can we make sure that they continue to be fit for service?

Humza Yousaf: Sir Lewis Ritchie wants to comment on that, so I will let him come in next.

It is fair to say that, in my session with the committee last week, there was rightly quite an intense focus on capital infrastructure. I can point to investments that we have made. Dr Gregor Smith mentioned a couple of new hospitals that we built and opened last year—I was very pleased to be a part of that. There is absolutely a role for what we might colloquially call shiny new buildings that are built to the best standards to accommodate the equipment and the technology, and meet best access standards, net zero ambitions and so on. Communities will always welcome such buildings. However, there is also a significant need for refurbishment of our NHS estate.

I think that, last week, Tess White referred to the significant refurbishment backlog. The Government is committed to significant investment in that refurbishment, and that investment has to be not only at our large acute sites—although many of them need refurbishment—but at some of the local community facilities.

10:45

Sir Lewis Ritchie: I was privileged to work in a community hospital in Peterhead for almost all of my career. At one point, I did a review to try to improve its potential. That included technical innovation.

It is probably time to look again at the utility of community hospitals in Scotland, particularly in relation to step up, step down rehabilitation and end-of-life care for those who are in the final

stages of their lives. Those issues are very important, and we need to look again at not just the infrastructure but the role that community hospitals fulfil.

The Deputy Convener: I will jump in on that point. In the context of our social care challenges, many people have recently spoken about that issue and the potential of going back to the cottage hospital model. Certain areas are certainly looking at the provision of step up and step down care in a more local sense. Would you be keen to see more of that?

Humza Yousaf: Again, Sir Lewis Ritchie might want to add to what I will say.

I have often been asked about a number of cottage hospitals from which, unfortunately, we had to take staff during the height of the pandemic to send them to large acute sites, and whether there is merit in bringing them back on stream to help us with the social care challenges that we face. I have raised that issue with the chief officer in Dumfries and Galloway in particular. Her response was very interesting. She said that the staff who were taken from particular cottage hospitals can offer more hours of care to more people receiving care at home. Instead of being able to look after 10 people at a time—I am making up the numbers for the sake of illustration—they were almost doubling that and were able to look after and provide care for almost 20 people in their own homes.

Cottage hospitals play an enormously important role within our health and social care services. Decisions about where the balance of benefit is in staffing and the care that the staff can provide have to be made at the local level.

I think that both my colleagues want to comment on that.

Sir Lewis Ritchie: I agree with that. We are looking at an amalgam or a panoply of services. Hospital at home has emerged as a service that was not talked about or delivered much 10 to 15 years ago. It is now online in a way that it has not been in the past.

We do not need a new building to call it a community hospital. We could have dedicated beds in a nursing home in which care that is more advanced than nursing home care, as we understand it, is delivered. We need to think laterally about that and not just think in terms of buildings.

Dr Smith: Sir Lewis Ritchie has already made some of the points that I wanted to make.

It is important that we do not just simply revert to the models of yesteryear. Practice has very clearly moved on. In particular, the ways in which multidisciplinary teams work together are very different now than they were even 20 years ago. Models such as hospital at home, which Sir Lewis Ritchie mentioned, are a really important aspect of the way in which we will deliver care across communities in future.

There will always be a need for step up, step down beds, particularly in rural areas, but the hospital at home model using multidisciplinary teams, in which we blur the artificial edge between primary and secondary care and have specialists working alongside community teams in that environment, is one for the future. It has an awful lot of benefits for the teams that are employed in it and especially for the patients who receive the care.

The Deputy Convener: We will move on to questions from David Torrance on the use of digital technology.

David Torrance (Kirkcaldy) (SNP): Good morning to the cabinet secretary and the other witnesses. The pandemic increased the use of digital technology. What impact has that increased use of digital services had in remote rural areas? I am conscious of time, so I will roll all my questions into one. What are the potential benefits and risks of a reliance on digital services in rural areas?

Humza Yousaf: I will answer the two questions and, again, I will be happy for my colleagues to come in. The pandemic necessitated not just the use but, frankly, the explosion in the use of digital technology, and we want to retain that where possible. Members often speak to me about some of the challenges that their constituents articulate to them about access to local GP services. I have always maintained that GP access should continue to be a hybrid model. Where people need to be seen face to face, that should absolutely happen. However, it is no bad thing to embed the use of technology such as video and telephone consultations.

The member knows about the growth in the Near Me system, and he will know that we have a digital healthcare strategy, which I am sure he has seen. I have often referenced the strategy in committee appearances, and I commend it to everybody. It talks about some of the forward thinking that we are doing on the use of digital tech. A recent example—it is small scale, but it is important—is the launch of the NHS 24 app during this winter. It is a minimum viable product, but it will grow and evolve as time goes on, and it could be another tool in the toolbox to try to ensure that people get the right care in the right place at the right time.

I could go on for ages about the importance of digital tech, which clearly can make a big difference in remote and rural healthcare. I could give numerous examples of how we are deploying

digital technology in remote and rural health settings. A number of campaign groups that I have spoken to have told me that that is significant and important to them. Clearly, however, the expectation is that anybody who needs to be seen face to face will be seen face to face. If that is not happening, I would be concerned.

On reliance on technology, we are cognisant of digital exclusion, and we clearly reference that in our strategy. We have to ensure that alternatives are available for those who are unable to connect digitally. The Government's number 1 priority is to ensure that everybody right across the country has appropriate connectivity. While that investment is being made, it is about making sure that we have alternatives to digital available.

I think that both my colleagues want to come in, with the convener's permission.

Sir Lewis Ritchie: We should not look at digital innovation just in terms of service delivery, although that is imperative and there are numerous examples of it. For example, there is SkyeLab in Portree, which has been looking at how best to deliver care near to home. There is also the dimension of the learning environment. One thing that we know about remote and rural areas—this goes full circle back to our earlier discussion—is that those who train and learn in rural and remote environments are more likely to stay there or return there to practise their disciplines. Digital innovation will be an enabler for that as well.

Dr Smith: I will make two points in this area. The first is about the inclusiveness of the use of digital. Interesting work is being done with Scottish libraries on how we begin to create networks that support people to be able to use digital technologies to engage more readily with clinical and care services. That work is really promising. Throughout our work on realistic medicine, we have worked with the Scottish Library and Information Council to try to develop those links and provide people with trusted sources of information in that context, so that they can participate in consultations using digital technology in a way that is much more productive for them.

Secondly, we should not lose sight of the professional-to-professional supports and benefits that digital technology brings. Some of that is about education and learning and how people can participate in online courses or meetings in a way that means that they are much more likely to feel part of a community and less isolated. It is also about the way in which people seek professional advice.

During my recent visit to Highland, I heard clear views from GPs and hospital consultants on the professional-to-professional sources of information that they now use in relation to individual patient episodes of care. That enables them to ask questions and share information, all of which is contained in the patient record in a very safe way, which enables the formation of an audit trail in the background.

Those advances in technology and its use very much benefit patients. They often allow referrals to be avoided because advice is sought in other ways.

David Torrance: Perhaps Dr Smith can give us more information—possibly later in writing—on the use of public libraries. They are community buildings that are well used and are usually central to communities, so I am interested in hearing about that aspect.

Dr Smith: I would be delighted to let the committee know about the work that we have been doing with SLIC on realistic medicine and the provision of trusted advice for people not just in rural communities but across Scotland.

The Deputy Convener: I think that the whole committee would appreciate that.

We will move on to questions from Evelyn Tweed on the capacity and resilience of services.

Evelyn Tweed (Stirling) (SNP): Good morning to the cabinet secretary and panel. How do winter pressures impact rural health boards differently from urban health boards? We have touched on that, but can those pressures be predicted and can we plan for them?

Humza Yousaf: We always do our best to do that. As soon as we have got through one winter, we start planning for the next. Of course, the remote and rural challenges can be significant. I will highlight two aspects that have been central to our planning for winter—and even before winter—with regard to the extreme pressures that we face in the NHS. We take a whole-systems approach to both the front-door and back-door aspects at our very busy acute sites.

At the front door, we try to reduce attendances, which is definitely having some purchase—we see that it is working, although we will continue to look at whether we can reduce attendances even further. We do that by ensuring that people get the right care in the right place at the right time through access to other services such as NHS 24, the pharmacy first Scotland service and out-of-hours general practice.

From a remote and rural perspective, that can be more challenging, because the nearest service might be further away from someone. Even if they have a car, access can be tricky, and if they do not have a car, it might involve taking a couple of buses. That can be tricky, and people might think, "If I'm unable to get there, perhaps the safest

option is to go to A and E", because they are worried about their condition, or a family member's. That is one of the real challenges.

Our colleagues in NHS boards—and particularly the remote, rural and island boards—have been working hard to try to make services as accessible as possible. That goes back to David Torrance's very good question on the use of digital. NHS 24 is a service from which anybody across the country can get clinical advice; it has a number of clinical supervisors who provide excellent advice.

At the back door, we know that one reason why we are facing such significant pressures this winter—I note again that we were facing pressures before winter, too—concerns the high levels of occupancy and delayed discharge in the system. Again, I highlight how important social care is, as it is critical for us to be able to discharge people who are clinically safe to be discharged. Looking at the landscape of social care, there is no doubt at all that those social care providers in remote and rural areas, both care-at-home providers and care homes, are really struggling. There are a range of reasons for that, but they include fuel costs, which are often higher in remote, rural and island settings. Our local health boards will work with those care providers to see whether they can make adjustments or provide any additional support to assist with those particular challenges.

To summarise, it is vital that we look at the unique winter challenges that those in remote, rural and island Scotland face. The answer to Evelyn Tweed's first question, which was about whether our remote, rural and island partners are involved in that winter planning, is yes—absolutely. Of course they are. I have given two examples, but I could give many more, of where there are unique challenges for places in Scotland with particular geographies. We are very alive to them and we are trying to assist during a very difficult winter.

11:00

Evelyn Tweed: Are the long-term impacts of cancelling routine surgery understood? What are those impacts and how can they be avoided or mitigated?

Humza Yousaf: I will hand over to the CMO shortly for him to add his clinical expertise, but it is fair to say that they are well understood. One of the most difficult decisions that was taken during the pandemic was the decision to pause elective care, and there is no doubt about the effect of that. If someone is on a waiting list, the effect of cancellation is not benign. People deteriorate and decondition. We are seeing people present sicker and with higher acuity, and that deterioration and deconditioning are contributing factors to that.

I regularly speak to orthopaedic surgeons in particular and to the Scottish collaborative orthopaedic trainee research network—SCOTnet, as it is known—and they often tell me that there is no doubt that given the difficult but, I would say, necessary decisions that were taken during the pandemic, people on waiting lists are deteriorating and deconditioning, particularly if they are on long waiting lists. That is why, when I announced certain targets in the summer, the focus was on those long waits, because we know that people who wait for excessively long times for elective care will come to harm. There is no argument from me on that. My goodness—when we speak to people who suffer with chronic pain, we can really understand from their perspective how detrimental that is to them, and I will not pretend otherwise.

In the context of the winter pressures, Evelyn Tweed will be aware that three health boards have taken the decision to have a time-limited pause on elective care. I stress the term "time-limited" because, although those are local decisions, I have made it clear to those health boards—they understand this and there is certainly no argument from them on it—that the measure should be in place for as little time as possible, given all the impacts that pausing elective care can have.

That is also one of the reasons why we did not move the entire NHS to an emergency footing during the winter. Some people called for us to do that, and I understand where those calls came from. However, if we had moved the NHS to an emergency footing, as we did during the early days of the pandemic, instead of three health boards pausing elective care, all 14 territorial boards would potentially have done that. That would have had a severe impact on people up and down the country.

Please forgive me for again giving a fairly long answer to a short question, but I hope that that gives you an understanding of the situation. I will bring in Dr Smith.

Dr Smith: First, I entirely agree with the cabinet secretary when he says that the decision to pause some of the elective programme during the height of the pandemic in particular was absolutely necessary. We should not forget just how stark a reality we faced at that time, but it has undoubtedly had a knock-on impact on people. Clinicians across the country are seeing the results of that and the on-going impact. The cabinet secretary covered some of the elements of that including deconditioning and the deterioration of conditions.

However, it also goes beyond the elective programme. The work that was paused or displaced by the impact of the pandemic is not just about the surgical procedures that were lost. People also responded differently to healthcare

during that time. They did not seek treatment as readily, for all sorts of complex reasons that we are beginning to understand. Treatment was displaced because of the sheer volume of infectious illness that people had to deal with, and we will see the impact of that for some time yet. We are starting to see the impact coming through with some chronic disease management. That was all foreseen and anticipated, but it is now being starkly realised in some of the outcomes that we are seeing with regard to people's long-term conditions.

For the future, there is an opportunity for all of us to redouble our efforts and focus relentlessly to address some of our past secondary prevention initiatives. That will ensure not only that we re-galvanise our approach to secondary prevention, but that we do not leave anyone behind—that we find ways to reach more effectively some of the groups that were often harder to reach, and that we can offer them those types of approaches.

Evelyn Tweed: Are people coming forward now, Dr Smith? You said that they did not come forward during the pandemic, for various reasons. Are they now seeking the care that they need?

The Deputy Convener: I am thinking about the relevance of the question to rurality and the petitions. Do you mean in a rural context, Evelyn?

Evelyn Tweed: Yes.

Dr Smith: Across the country, we are seeing a return to people seeking help. However, at this stage, the activity levels in many areas have not reached pre-pandemic levels.

The Deputy Convener: I am conscious of time. We have a number of questions to get through, so we will move on to questions on the workforce.

Gillian Mackay: We have an ageing population. We heard during our national care service visit to Dumfries and Galloway that a higher number of people are retiring there, which increases pressures on certain areas of services. What work is under way to ensure that, with regard to the workforce, we take account of that potential change of demographic, and particularly the potential skewing due to people retiring to certain remote and rural locations?

Humza Yousaf: I referred to the RCN round table that Gillian Mackay and I both attended. I will not reiterate everything that I have said about the retire-and-return policy, but I am happy to provide more detail to the convener, who could share it with committee members.

First, that policy came as a direct result of our hearing nurses in particular say that, after 20, 30 or 40 years in the profession, they were thinking of leaving because of the inflexibility around the possibility of retirement and return. Many of them just wanted to reduce their shifts, but the inflexibility of the system did not allow them to do so.

Secondly, it is worth reiterating the obvious point that one of the most significant things that we can do to try to retain our workforce is to reduce workload pressure. All of us round the table have spoken to NHS staff, and whether they are nursing, medical or midwifery staff, they always use the word "relentless" to describe the past three years. They have often told me that in a typical NHS career in a hospital—the same thing happens in community, primary and secondary care—they gear themselves up for the winter, during which they know that they will have a rough few months, then the pressure begins to ease, and they then gear themselves up once more as we get towards winter again. In effect, however, that has not happened for three years: there has just been relentless pressure.

Notwithstanding how difficult the past few weeks have been, the work that we are doing to try to reduce workload pressure means that, although it will not be easy, we will begin to see an easing of the most extreme pressure that we have seen throughout the winter. The question is what we can do to try to stabilise the service so that it does not feel as relentless as it has felt in recent months and years.

Pay is important. We cannot skirt that issue. Ensuring that people who work in our NHS and indeed in social care are appropriately rewarded is really important. I will not rehearse again everything that I have already said on that, but we have a fair pay offer on the table. Gillian Mackay will know that, at the end of last week, we came to an agreement with the three trade unions that were in dispute and had a strike mandate that they will pause strike action, and we will enter negotiations on 2023-24 pay this week.

Pensions are really important, too. The point on the disincentive around pensions comes up regularly, particularly from the medical workforce. I will not rehearse again what I have already said, but the Government can take and has taken action in relation to the BMA wanting to go further with pensions.

That is important in a rural setting. It is important everywhere, but the real advantage of a rural setting is the improved work-life balance that attracts people to work there. For retention purposes, we have to work and are working across Government and across portfolios to deal with housing, education and later-life provision for people, all of which has to form a holistic package.

Again, please forgive me for giving a long answer. I think that Sir Lewis wants to comment.

Sir Lewis Ritchie: Again, I agree with what the cabinet secretary has said. Careers used to be linear, but they are now more complex, and workforce planning needs to recognise that. At one point, workforce planning was thought to be about getting the numbers right. That is still important, but it is not the whole position. We now need to be much more proactive in supporting career development, because that in itself will help with retention.

We are in very difficult circumstances, as the cabinet secretary has said so eloquently. However, looking to the future, we need to be much more alive to career development and recognise that, with seniority, individuals might wish to develop their skills in a different direction according to the skills and expertise that they have accrued over many years. We need to look at the issue in a number of ways. The number of staff is just the start of the process.

Dr Smith: We have not spoken about what ScotGEM offers in producing medical students and new doctors who are much more likely to go and work in a rural environment. Not only has it done that, but it has galvanised the careers of the educators who are providing the education to those medical students and new doctors. In the discussions that I have had with trainers, they have spoken about how much more they are enjoying their careers since they have been able to participate in ScotGEM. That speaks to Sir Lewis's point that careers are complex and that we need to do something to sustain them.

Gillian Mackay: I had the absolute privilege of visiting some school nurses in Falkirk a few weeks ago, and it was incredible to see the amount of preventative work that they do. They are hugely passionate and innovative in what they do. In rural and remote areas, their preventative work on health could be extremely important. Given the potential impacts of certain practitioners on keeping people well—resulting in fewer attendances at acute settings, which is important—and given some of the distances involved in remote and rural areas, what planning is under way to ensure that we have a diverse mix of recruitment and that we do not lose sight of really important healthcare professionals, such as school nurses?

Humza Yousaf: That is a great question, and it is why so much of our focus has been on growing multidisciplinary team staffing in general practice and beyond, in primary care and other parts of the health service. Our ultimate goal is to ensure that people get treatment at home, if possible, or as close to home as possible. I would argue that that is just as important, if not more important, in remote and rural settings, given the challenges to access to secondary care. The focus on primary and community care is exceptionally important in that regard. A lot of our focus has therefore been on growing multidisciplinary teams, and the number of people in those teams has grown to more than 3,220 in the past number of years.

On the preventative side, we can focus on investment in allied health professionals. Clearly, if someone gets access to an allied health professional before their condition becomes a lot worse, there might be a lot of benefit in that from a preventative perspective. I have always been incredibly impressed by how much our advanced nurse practitioners can do, so embedding them in community facilities, particularly in primary care, can really help us.

I just want to make a final point, which Gillian Mackay made in her question. In the health service, we often have to deal with the immediate, so let us deal with the immediate winter pressures that are in front of us. However, I am keen that we, as a Government, never lose sight of the importance of the preventative agenda. I focus on that regularly, as I am sure members can imagine. Although we have had to deal with and prioritise the difficult challenges of the pandemic, we do not want to lose any focus on the excellent preventative work that we are doing on obesity, mental health, smoking cessation, alcohol and drugs, healthy living and so on. Maree Todd, as the minister with responsibility for public health, is leading on that, and—as members may imagine—she is driving that work forward at pace.

11:15

The Deputy Convener: I am conscious that five colleagues want to ask questions on broader workforce issues relating to recruitment, retention, accommodation and training. It would be helpful to get through those questions, so I ask for more succinct questions and answers.

I will bring in Tess White first.

Tess White: Over the festive period, NHS Grampian made an extraordinary plea on social media for exhausted NHS staff to come in on their days off. Dr Iain Kennedy—who is chairman of the British Medical Association Scotland, as members will know—said that that intervention should

"close any debate that the NHS is broken".

The issue of how strapped for staff NHS Grampian is has been well publicised. Does the cabinet secretary think that that will happen more often? Is it acceptable for that to become the norm?

Humza Yousaf: No—it is definitely not, and should never be, the norm. In Tess White's articulation of her question, she referred to the fact that that was an extreme measure taken by NHS Grampian, and I never want to see it as the norm.

Objectively, I think that, if we all take a step back, we can agree that the festive period—the few weeks running up to Christmas, the Christmas period and the first week of January—was among the most difficult periods, or probably even the most difficult period, that the NHS has ever faced, certainly in the course of the pandemic and, I would argue, possibly in its entire existence.

There were really difficult choices to be made, including the pausing of elective care, which I will highlight before it is mentioned. I do not want to see that happen. The constituents who write to me and to Tess White, and to every member around the table, are suffering because of a last-minute cancellation, again, of an operation for which they have already been waiting a year or more. We do not want extreme measures.

Tess White is right to say that the workforce is exhausted—I will not argue with her on that. I speak to many people on the front line, and they tell me about the exhaustion, so I am very grateful for all that they do and for the fact that many of them responded to that particular call.

However, I would not simply be aghast if that were to become the norm; I would not allow it to happen. It was an in extremis measure that, I hope, we will not have to repeat. Nevertheless, it is important that local health boards are given flexibility to make those difficult decisions.

Sandesh Gulhane: Scottish Conservatives have, through a freedom of information request, discovered that people are waiting a long time for diagnostic tests. Why is that relevant to rural areas? Well, in NHS Grampian, there is a five-year wait, and in NHS Tayside, there is a four-year wait. Why is there such a bottleneck in radiology and diagnostic testing, as we know has been the case for a long time? What have you done, and what are you doing, about it?

Humza Yousaf: That is a good question, because it is clear that a delay in diagnostics has the potential to have a real impact on an individual's health outcomes. None of us wants to see any delay in diagnostics.

Dr Gregor Smith and I were involved in the press briefing yesterday, and the issue of diagnostics came up on the back of the FOI request and relevant articles. I will say a few things in response. First, the pandemic has had an obvious impact. That situation is not unique to Scotland; it is replicated not just across the UK but around the world. People have had to make exceptionally difficult decisions.

Dr Smith and I spoke about the difficult decisions that were made on elective care. I do not think that I would be overegging it to say that one of the most difficult decisions, if not the most difficult decision, that was taken during the pandemic was on the pausing of cancer screening. It was paused only for a brief period, but even a single day of pausing screening can have an impact, let alone pausing it for a period of months, as we had to do in the early days of the pandemic. Such a decision is never taken lightly, but those decisions were taken as a result of the pandemic, and they had an impact on our health service, which is why there is a backlog of that scale. I am not suggesting that there were no delays in diagnostic testing before the pandemic, but I think that an objective observation of the figures would show that the pandemic had a significant impact on the level of delay.

In the information that resulted from the FOI request, I noticed that a few people had, unfortunately, waited for far too long. I will go back to what the First Minister said yesterday: no one should be waiting for as long as five years, as happened in one case. That is an absolute anomaly. We need to understand why that happens in individual cases, because even if that happens in only one case, or in a few cases, it will have an impact on the individual who is involved. However, waiting for that length of time is not the norm.

What are we doing about that? I will double check the detail, but we have invested in, I think, six mobile MRI scanners and five mobile CT scanners. That is relevant to rural Scotland. The investments that we have made thus far have provided some additional capacity. We have also looked at the winter pressures that we have clearly faced and are facing, and I have put an additional £1.5 million towards diagnostic and radiology services. From memory, that will give us in the order of 15,000 additional scans between January and the end of March. I will double check that number, and if I am way off, I will come back and correct the record. We will keep investing to try to increase the capacity of diagnostic services where we can.

The Deputy Convener: We need to move on, as we are very short of time.

David Torrance: A friend of mine had a position in NHS Highland to go to, but after three months of searching, they could not find suitable accommodation. I have strong connections to Aviemore, where the residents welcome the new community hospital. However, once again, there is no accommodation, unless you want to pay £600 a week for a holiday let.

In your opening statement, you mentioned that the University of the Highlands and Islands had increased the number of its places by 33 per cent. Will we not lose people from such areas if there is no accommodation? Is lack of affordable accommodation the biggest barrier to recruitment and retention of staff, and how can we fix it?

Humza Yousaf: First and foremost, there is no doubt that housing is an important issue. I hear from many people who have tried to take up rural, remote or island posts that lack of housing is, ultimately, the reason why they cannot do so. In some cases, education might be the reason, but housing tends to be the problem.

I understand that brevity is important, so I will be brief. There is a relentless cross-Government focus on the issue. I meet colleagues who have responsibility for affordable housing, and together—as the member probably knows—we are developing a remote, rural and island housing action plan in order to meet the housing needs of those communities. There is a real focus on retention and attracting people to those communities. It is fair to say that we welcome innovative local solutions that can be found. That is happening in parts of Scotland where accommodation is being repurposed. However, there needs to be a cross-Government approach, which is why the remote, rural and island housing action plan is important.

The Deputy Convener: I am conscious that three colleagues are looking to ask questions. Cabinet secretary, are you content in terms of time, given that we have subsequent business?

Humza Yousaf: Yes, although I have work to do relating to topical question time and the debate later today.

The Deputy Convener: We will certainly try to make that work.

Carol Mochan: My question is about workforce training, which is quite a wide subject. I understand that the cabinet secretary will not be able to answer all aspects of the question, but I am interested in whether NHS Education Scotland has done a lot of work on rural training and clinical places. I am interested in the notion of local places, because I believe that there is sufficient evidence to suggest that, if people can be trained locally and we can get people into those areas, we will be able to retain staff, because the jobs are interesting. There is a wider issue relating to the different professions—AHPs and nurses, for example—but I am interested in what engagement you have had with NHS Education Scotland.

Humza Yousaf: First, there is no doubt that the feedback overwhelmingly suggests that, if we can train people locally, there is a better chance of retaining them locally.

I will not rehearse what has already been said about the ScotGEM programme, but our GP fill rate for that in the north of Scotland is exceptionally good. I have mentioned the shortened midwifery course, which involves distance learning so that people can stay in their localities while they study and train to become midwives. We are already doing a lot in that space.

I have said to health boards that they should be as innovative as possible. We are looking at how many of the additional training places that we have made available for the medical workforce can be filled by those from remote, rural and island health boards.

For the sake of brevity, it is worth saying that there is no doubting the premise of Carol Mochan's question. A fair bit of work is going into making sure that we have as many training places as possible in remote, rural and island Scotland, whether those are for nursing, midwifery, GPs or other parts of the medical workforce.

I know that we are tight for time, but Sir Lewis Ritchie probably has the necessary expertise to comment on that.

Sir Lewis Ritchie: NES, in particular, is doing good things. There are specific training programmes, including the rural fellowship programme. There are ambitions beyond that in relation to multidisciplinary teams and in the direction of social care. That is essential if we are to have an integrated approach to the care of the people of Scotland.

Many good things are going on in remote and rural areas right now. I hope that the new national centre for excellence will amplify those things and that NES will have a prominent role in that regard.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): It was great to hear Dr Smith talk about how ScotGEM has galvanised the careers of the trainers he spoke to; it also made me think back to Sir Lewis Ritchie's comments about the success of the rediscover the joy campaign.

We are incredibly lucky in Scotland to live in such a beautiful, amazing country, not least our rural areas, which can be very attractive to students. Could we further develop ScotGEM or extend it to undergraduates, too? What opportunities and challenges would there be in that regard?

Humza Yousaf: I will let Dr Smith come in in just a second, as he has been integral to the ScotGEM programme. We have already grown the intake. We often get calls for health boards that are not part of the ScotGEM programme to be involved—in fact, the convener is one of the advocates for the expansion of that programme.

Now that we have had the first cohort of graduates, it is important to ensure that the programme is stabilised before we consider expanding it to additional health boards, for example. At the moment, as you say, it is a graduate entry programme. I think that extending it

to undergraduates would be challenging and quite disruptive to a model that we are trying to stabilise.

The programme is hugely popular, and we should be open minded about potential expansion in the future. My view is that, at the moment, we need to ensure that it is stabilised and that we are getting the benefit from the programme. Dr Smith might be able to add to what I have said.

Dr Smith: There is some expansion of the number of ScotGEM places this year, which is positive. We have to be careful that we do not grow the programme too quickly, because we do not want to overwhelm the training opportunities and dilute the training experience that people get through the programme, as that is a really important aspect of it.

I have spent time with some of the students as they go through the programme—I was lucky enough to provide a lecture for them a couple of months ago—and they are enthusiastic and insightful learners who are keen to get out there, who understand the challenges that exist in the system and who are not short of ideas about how they will try to contribute to addressing those challenges.

It is a very positive experience to be anywhere near that programme, but we need to make sure that we grow it in a proportionate way over time so that we do not dilute the content.

Emma Harper: I have a quick question on education and skills. The mobile skills unit was developed in order to deliver education in more rural areas. A big lorry-sized van provides simulated training for chest tube insertions or even intraosseous needle insertions, for example, and I know that it has been all over Scotland. Is there an opportunity to focus more on that kind of education delivery in remote and rural areas, using the managed skills network or the clinical skills network?

Humza Yousaf: I could be very brief and just say yes. There is the potential to use digital or mobile technology and equipment to deliver training. I have seen fantastic examples of simulators in our training facilities. It is incredible just how real it feels—even as a non-clinician, I could feel my heart racing as those who were training were dealing with a medical emergency in that simulated environment. In short, yes, we are exploring that and seeing what more we can do in that respect.

The Deputy Convener: I thank the cabinet secretary very much for his attendance and for his indulgence as we went over our allotted time. I also thank his officials for their attendance.

I suggest that, following the evidence that we have heard this morning, the committee considers our next steps on the petitions at a later meeting. Do members agree to do that?

Members *indicated agreement.*

The Deputy Convener: We will have a short comfort break.

11:31

Meeting suspended.

11:36

On resuming—

Subordinate Legislation

Dentists, Dental Care Professionals, Nurses, Nursing Associates and Midwives (International Registrations) Order 2022 [Draft]

The Deputy Convener: Our third agenda item is consideration of an instrument that is subject to affirmative procedure.

The purpose of the order is to amend the legislative framework underpinning regulators' international registration routes. In particular, the order enables the General Dental Council to set out and change its processes for international registration more efficiently, including by providing updated powers for the General Dental Council to charge for services that it undertakes.

The order also allows the Nursing and Midwifery Council more flexibility in the range of international testing routes to ascertain applicants' competence, and changes rules that set out registration processes in order to reduce the time that is taken to process international applications.

The Delegated Powers and Law Reform Committee considered the order at its meeting on 13 December 2022 and made no recommendations in relation to it.

We will now hear evidence from the Cabinet Secretary for Health and Social Care and supporting officials on the order. Once all our questions have been answered, we will proceed to a formal debate on the motion.

I welcome again to the committee Humza Yousaf, the Cabinet Secretary for Health and Social Care. I also welcome, from the Scottish Government, Rachel Coutts, who is a solicitor in the primary care, medicines and treatments branch, and Rebecca Wright, who is a senior policy manager in regulation of health professions in the chief nursing officer's directorate. Thank you for joining us today.

I invite the cabinet secretary to make a brief opening statement.

Humza Yousaf: Thank you, convener. Long time no speak. I am keen to take any questions that the committee might have.

As you heard in the session that we have just concluded, it is so important that the health service is able to meet intense challenges, such as we are currently facing, as they arise. The order gives additional flexibility to the GDC and NMC to help the health service to respond to some of those challenges.

Since the end of 2020, European law on recognition of qualified healthcare professionals from the European Economic Area no longer applies in the UK. Current stand-still arrangements mean that the UK professional healthcare regulators continued to automatically recognise EEA and Switzerland-obtained qualifications for up to two years after the end of the transition period. The period of automatic recognition ends in early 2023, when the Secretary of State for Health and Social Care will review the approach to registering professionals who have qualified in the European Economic Area.

The order is being made under section 60 of the Health Act 1999. It will amend the Dentists Act 1984, and the Nursing and Midwifery Order 2001 and other subordinate legislation. The order will change the legislative frameworks of the GDC and the NMC to allow them to amend their registration processes for international applicants.

Both the General Dental Council's and the Nursing and Midwifery Council's governing legislation prevents them from making changes to their registration processes. In the case of the GDC, the legislative structure makes it quite difficult and time-consuming to make changes to its registration process. Likewise, the NMC must follow an overly detailed procedure to carry out assessments for international applicants.

The order makes a number of changes to the legislative framework on the NMC's and the GDC's international registration requirements. First, it allows the GDC to apply a range of assessment options to determine whether applicants have the right knowledge, the right skills and the right experience to practise in the UK.

Secondly, it removes the requirement for dental authorities to use an assessment for overseas applicants, such as the overseas registration exam, known as the ORE.

Thirdly, it allows the GDC to charge fees to international institutions for expenses that are incurred in relation to international registration, so that it can cover the costs of recognising international qualifications that meet UK standards.

Fourthly, the GDC will be able to make rules that set out the details of its international registration processes without the need for Privy Council approval, so that that change can be made far more efficiently.

Fifthly, a transitional period for the ORE will continue to apply for 12 months after the order comes into force, at which point the GDC will

publish new rules for its international registration processes.

Subject to parliamentary approval, of course, the effect of the order will be to allow the GDC to use increased flexibility to set out two international registration routes based on an assessment of an applicant's qualifications, skills or training, and completion of an ORE-style assessment, and the recognition of an applicant's qualifications where the GDC has assessed that qualification and considers that it provides applicants with the required knowledge, skills and experience.

With regard to the changes to the Nursing and Midwifery Order 2001, the NMC will continue to apply its test of competence as the main assessment route for international applicants, which will remain in the legislation as one of the ways that the NMC can ensure that an applicant meets its standards.

However, the order will bring in other pathways for registration. First, there will be recognition of an NMC-approved programme of education from outside the UK. Secondly, in limited situations, there will be a qualification comparability exercise, which the NMC will use to judge whether the applicant's qualification is of a comparable standard to an NMC-approved UK qualification. In either situation, applicants would still need to meet the NMC's other registration requirements, such as on English language, indemnity and payment of the registration fee.

I fully support the instrument as a pragmatic solution that will improve consistency and give the regulators much-needed flexibility in responding to the changing circumstances. I am happy to answer any questions that members have.

The Deputy Convener: Thank you. I invite questions for the cabinet secretary.

Emma Harper: It seems reasonable that the order provides the GDC and the NMC with greater flexibility to amend their existing international registration pathways. I know that there are challenges with regard to access to NHS dentistry, especially in my region of Dumfries and Galloway. Will the order ultimately help us with recruitment of dentists and dental practitioners, especially with regard to the issues that are a consequence of Brexit?

Humza Yousaf: I certainly hope so. When I have spoken to the NMC and the GDC in my time as health secretary, they have been excited—as excited as regulators tend to get—about the fact that the additional flexibility could really assist with international recruitment. I will not go into the challenges that Brexit has brought in relation to health and social care because those have been well rehearsed, but flexibility can absolutely help with that.

As per the previous evidence session, there is no doubt that health boards want to take maximum advantage and make maximum use of international recruitment. It is not a panacea—I am always keen to say that—but it can provide significant additionality. There is no doubt that the additional flexibilities that I outlined in my opening remarks could help with regard to the dental and the nursing and midwifery workforces.

The Deputy Convener: There are no further questions, so we move to the formal debate on the affirmative instrument on which we have just taken evidence from the cabinet secretary. I remind the committee that members should not put questions to the cabinet secretary during the formal debate and officials may not speak in the debate.

Cabinet secretary, do you wish to say anything further on the motion?

Humza Yousaf: I have nothing further to say.

The Deputy Convener: Thank you. I invite contributions to the debate.

As there are no contributions, I ask the cabinet secretary to move motion S6M-07061, which is in his name.

Motion moved,

That the Health, Social Care and Sport Committee recommends that the Dentists, Dental Care Professionals, Nurses, Nursing Associates and Midwives (International Registrations) Order 2022 be approved.—[*Humza Yousaf*.]

Motion agreed to.

The Deputy Convener: Thank you. That concludes consideration of the instrument. I thank the cabinet secretary for his time and his officials for attending.

At our next meeting, we will take evidence from Cricket Scotland and sportscotland to get an update on their response to the independent review of racism in Scottish cricket. We will then take evidence from representatives of Food Standards Scotland. That concludes the public part of our meeting today.

11:46

Meeting continued in private until 12:06.

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