OFFICIAL REPORT
AITHISG OIFIGEIL

# Health, Social Care and Sport Committee

**Tuesday 5 September 2023**

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

# Tuesday 5 September 2023

## CONTENTS



## HEALTH, SOCIAL CARE AND SPORT COMMITTEE

**24th Meeting 2023, Session 6**

**CONVENER**

*Clare Haughey (Rutherglen) (SNP)

**DEPUTY CONVENER**

*Paul Sweeney (Glasgow) (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:**

John Burns (NHS Scotland)
Nicky Connor (Fife Health and Social Care Partnership)
David Gibson (Social Work Scotland)
Caroline Lamb (Scottish Government)
Dr John-Paul Loughrey (Academy of Medical Royal Colleges and Faculties in Scotland)
Pamela Milliken (Aberdeenshire Health and Social Care Partnership)
Angie Wood (Scottish Government)

**CLERK TO THE COMMITTEE**

Alex Bruce

**LOCATION**

The Sir Alexander Fleming Room (CR3)

# Scottish Parliament

## Health, Social Care and Sport Committee

*Tuesday 5 September 2023*

*[The Convener opened the meeting at 09:15]*

## Decision on Taking Business in Private

**The Convener (Clare Haughey):** Good morning and welcome to the 24th meeting in 2023 of the Health, Social Care and Sport Committee. I have received no apologies for today's meeting.

Item 1 is for the committee to decide whether to take items 4 to 6 in private. Do members agree to do that?

**Members** *indicated agreement.*

**The Convener:** Thank you.

## Winter Planning 2023-24

09:15

**The Convener:** Item 2 is the first of our two sessions on winter planning. I welcome to the meeting Nicky Connor, who is the director of Fife health and social care partnership; David Gibson, who joins us remotely, who is chief social work officer at Argyll and Bute Council, chair of the workforce and resources standing committee at Social Work Scotland, and is here representing Social Work Scotland; John-Paul Loughrey, who is also joining us remotely and is vice-president for Scotland of the Royal College of Emergency Medicine, and is here representing the Academy of Medical Royal Colleges and Faculties in Scotland; and Pamela Milliken, who is the chief officer of Aberdeenshire health and social care partnership.

We move straight to questions from Sandesh Gulhane.

**Sandesh Gulhane (Glasgow) (Con):** Thank you, convener.

Good morning, and thank you for coming in for our first meeting of the new term. My first question is directed at Nicky Connor and Pamela Milliken, if that is okay. As we saw last year, when it comes to winter planning the focus is on what is going on in accident and emergency departments and hospitals. However, in primary care, general practitioners cannot call a code black and say that they are overwhelmed and that it is impossible to do what they are doing safely. I was at work during the summer, when it was almost like that. When I was on call, I was doing things at a speed that was not overly safe, but things had to be done that way because that is how we got through the number of patients who were needing help. What plans do you have in place for primary care come the winter?

**Pamela Milliken (Aberdeenshire Health and Social Care Partnership):** I will just outline a wee bit about what is happening in Aberdeenshire. Aberdeenshire health and social care partnership is a large rural partnership and we have practices that cover that whole area. You are correct to say that practices are already under significant stress. The partnership has practices that we have taken over as 2C practices, so we already know that there are sustainability issues for those practices. You are also correct to say that, in the roll up to winter, they become more pressured because of the need that comes through the door.

One thing that we have done throughout the year is provide sustainability support for practices. We have a lead GP for sustainability who talks to practices and looks at whether there are areas in

which we can support them, perhaps with the multidisciplinary team that has been put together through the primary care improvement fund. We are looking to maintain that sustainability as we go into the winter.

We also work closely with our local medical committee and our GP sub-committee. They have just brought in a method of identifying when practices are at a higher level of escalation. We used a home-grown version of that last year, but we are now using the general practice administration system for Scotland—GPASS—which has been more widely adopted, so that we can see at a glance which practices have identified that they are under more pressure.

Last year, we invested additional funding in anticipatory care planning. During Christmas and throughout the really high-pressure areas, we tried to get that support to practices so that we could try to anticipate the needs that would be coming through.

Also through our clinical leads, practices use what is called daily system connect across the whole of NHS Grampian. Primary care feeds into that and we are therefore able to identify particular issues. In Aberdeenshire, our primary care leads connect every morning and practices contact them if they are at a particular level of escalation.

We therefore have good communications about what practices are struggling and we try, where we can, to factor in support from, say, advanced practitioners or community treatment and care staff for practices that might be going through particularly difficult times. I think that we are aware of the pressure on practices and we are trying to support them and their sustainability more generally, but we are being more flexible in respect of our support when we get a call from a particular practice.

I hope that things such as the vaccination programme, which we are now working to accelerate, will allow us somewhat to contain the demand that comes through. I can also give you a bit more information about our 2C practices, if you are interested.

**Nicky Connor (Fife Health and Social Care Partnership):** With regard to Fife, I first of all echo what has been said about how critical primary care is in supporting people. It is the first point of contact for nearly everybody in our communities; it covers general practice, community pharmacy, optometry and dental practice, and there have been challenges in all of those areas.

Our primary care strategy, which we launched in March, looks at three key areas. The first area is recovery, in recognition of the fact that the doors of general practice did not close during the pandemic; indeed, they continued to be open to support people in their local communities. The strategy also looks at quality and sustainability. I should say that, similar to the situation that Pamela Milliken has just discussed, we have 2C practices in Fife, too, and we have been supporting those practices to return to independent status and have been looking at how we work alongside them to enable that to happen.

Something that I think might be unique in our approach is how we define our operational performance escalation levels. Every single morning, we have a specific primary care huddle that brings together the clinical leads and operational services. A few years ago, I redesigned the health and social care partnership so that we now have a primary and preventative care division, with its own head. I think that that has been critical in supporting engagement and leadership with regard to general practice. Every morning at 9 o'clock we have a whole-system huddle to consider the pressures on acute care, across all our community services and across primary care services, which enables us not only to take real-time action on the day if we are facing particular challenges but to take forward our planning work for the winter period.

I also highlight our governance, in this respect. We have established a primary care oversight group that is co-chaired by me and the medical director, and meets roughly every six weeks to receive feedback and reports from all our areas. The approach has supported us over the summer, when things have remained pressured, and in our planning going into the winter.

**Sandesh Gulhane:** In the light of what Nicky Connor has said about the real-time action that is being taken, and Pamela Milliken's comments about being more flexible and the things that are being done, I wonder whether both witnesses can follow up on their comments in writing with more information about what all that means.

I want to turn from primary to secondary care and ask John-Paul Loughrey from the Royal College of Emergency Medicine a question. On your data on people dying as a result of waiting in accident and emergency departments too long, we, too, have found that the number of people dying in A and E after waiting more than four hours has gone up 164 per cent since 2018. Are you concerned that we are going to see that situation escalate this winter?

**Dr John-Paul Loughrey (Academy of Medical Royal Colleges and Faculties in Scotland):** Hello again, and thank you for having me.

It would be fair to say that last winter was the worst that we in emergency care have experienced for a generation, and that it was probably the worst in the history of the national

health service. There were long delays in emergency departments for many patients—mainly the vulnerable and the elderly, but also some other groups who are more prone to long waits in emergency departments. For example, there is some evidence that women have to wait longer in emergency departments, as do elderly people and patients with mental health problems.

Last year's winter plan focused on crisis mitigation and some short-term measures, but there has been no longer-term strategy to avoid more winters like the last one and we have not really seen abatement of the pressure on emergency departments—and, indeed, across primary care and all the acute specialties—that we normally see in the summer. Instead, what we have seen this year is a decrease in our workforce. The workforce is dwindling across all sectors in Scotland, as is evidenced in the NHS Education for Scotland Turas data that was released in June, and so far we have not seen any future planning that involves anything more than simply trying to deal with the next winter crisis.

I have asked the other medical royal colleges extensively about what they think of winter planning in general, and the unanimous view is that this is no longer a winter problem but an "NHS in crisis" problem, and that short-term winter reactions are merely crisis mitigation. We know that we have a workforce problem as well as an overall capacity problem, which is partly a product of the tenacious delayed discharges numbers in hospitals. The latest data, from June, shows that there are still around 1,700 patients on delayed discharge in Scottish hospitals, and we know that the reduction over the past 10 to 15 years in the acute and general bed base has probably gone too far and that we now have too few beds in Scotland to deal with the winter surges coming on top of a system that is already over capacity and overstretched.

Finally, on your question about the increase in mortality, there is now a wealth of data that demonstrates that ED crowding is associated with mortality, including our own data that was published in the *Emergency Medicine Journal* and which has been used extensively to try to model and estimate the number of additional deaths that are associated with long ED stays. There is also data from Switzerland, Sweden and the USA that demonstrates that ED overcrowding is associated with poor outcomes and increased risk of death. Unfortunately, if we have a winter like the previous one—this has been borne out in National Records of Scotland data, which show an increase in mortality last winter of 6 per cent above the average—we can expect a similar risk of increased deaths.

**Sandesh Gulhane:** Thank you.

**Evelyn Tweed (Stirling) (SNP):** Good morning. My first question is for Nicky Connor.

Many responses to our inquiry highlighted the importance of social care in robust winter planning, but many respondents said that, last year, we did not account for that sufficiently. What would you like to be done differently this year?

**Nicky Connor:** It is, I think, about planning. I echo the comment that was made about the full-year effect: planning for small bumps is not what we require. Instead, we must be able to plan for the full year, and we must be thinking now about 2025-26 and looking at what we need to put in place. The fact is that when—or if—resources become available for a period, we have to recruit the workforce to be able to do these things. We have to bring certainty in relation to the workforce.

We would also be, and are, very committed to recognising the value of integration. Health and social care partnerships bring together all the sectors—not just our statutory services but our third and independent sectors. I highlight that specifically as being important to the sustainability of social care. We need to look more at sustainability for our independent sector colleagues.

One example from Fife that I will share is the care-at-home collaborative that we have created and which brings together 27 providers in Fife. We have put in place technology called Pin Point Health and Social Care that allows us to see where people across our system require care, and to work differently with our providers to see who is best placed to respond. That has not only helped us to maximise capacity in our system but has created a collaborative "Team Fife" approach in which we know that we are all in this together and that we are not competing but completing with regard to how we are working together to meet the population's needs.

I would say, therefore, that my answer is two-fold. We need the ability to carry out longer-term planning, with the resources that we accordingly need, and we need to maximise the benefits of integration to ensure that we work together in that collaborative way.

**Evelyn Tweed:** The responses also highlighted the high levels of fuel poverty, which is obviously causing issues for people who are trying to heat their homes and so on. I have read about the pilot in which doctors were prescribing heating and the real impact that that seemed to be having. Do you know of any other such pilots or services where people are thinking outside the box and are focusing not just on what needs to be done when patients present, but on how we can help to ensure that they do not have to come in in the first place?

09:30

**Pamela Milliken:** I can pick that up. Last year in the Grampian area, the public health service worked with one of the energy companies on support for energy bills in Scottish index of multiple deprivation areas. It was able to pinpoint areas and support was made available. That was tested in Aberdeen city, then the view was taken that we could learn from that and perhaps encourage the energy company to do that on a more widespread basis. Individuals were pinpointed for extra support.

In Aberdeenshire, we work closely with the council, which, coming up to winter, has a lot of initiatives related to the cost of living and support for families. A lot of information and support went out to communities about the things that we could help with in relation to the cost of living and fuel poverty. Aberdeenshire is often affected by bad weather, including snow and high winds, so we also worked with the council and its front-line staff to prepare families and carers so that if there was, for example, a power cut or something like that, we could make available and deliver packs of torches, blankets and so on, thereby helping to respond to crises.

We are also part of the PARD—persons at risk database—scheme, which for identifying vulnerable people. Aberdeenshire specifically was a bit further ahead because we work with the council. Through our management system for social care, Carefirst, we were able to identify people who might be vulnerable—in particular, to being cut off because of floods or bad weather, for example—so that we could provide social care and get support, through a wider local team response, to support individuals if we cannot contact them. We have a list of vulnerable people so that action can be triggered and pulled off when there is a weather incident. We can make sure that those people are contacted, that we visit them and that we have contact details of families or neighbours so that we can ensure that we know that everybody is safe. One of the things that we have learned through our response to resilience is how to make sure that we keep people safe over winter and during peak periods.

**The Convener:** I am keen to pick up on a point that Pamela Milliken made about the impact of the cost of living crisis on numbers of presentations and the health of the general population. Is the crisis impacting on presentations at A and E or GP surgeries, and is it exacerbating ill-health and making health deteriorate?

**Pamela Milliken:** Yes—we have seen higher levels of need for treatment for mental ill-health. We are also seeing a need for greater complexity in care.

Aberdeenshire has an ageing population and it is sometimes difficult to identify whether some of the need that is coming through is because of that ageing population. We are expecting around a 28 per cent increase in the population of older people between 2018 and 2030, so we are at the beginning of quite an escalation in the ageing population.

We also see a lot of people with complex needs coming through; the view is that they might be people who did not present so much during Covid and are now presenting later. We therefore have people with more complex needs coming through, as well as having an increase in our adult support and protection presentations. People are coming through who are in mental health crises.

A couple of years ago we all received winter money. One of the areas in which we have able to invest that is adult support and protection so that we can get to individuals and support them in their situations. Higher levels of need are definitely coming through.

In terms of social care, 70 per cent of our social care is commissioned and 30 per cent is in-house. We focus our in-house re-enablement complex care on being more responsive in relation to delayed discharges and pulling people out of acute hospitals. We have found that our team's case load has increased and that the dependency of the people who are coming through is higher. We definitely have more dependence coming through and some of that will be because of the cost of living crisis.

The other point to make about the cost of living crisis is that it also affects our staff, which is key for us. Earlier, Nicky Connor talked about some of the issues that are facing social care. I face challenges in recruitment to social care, particularly in rural areas where the alternative work that people can get offers more attractive wages.

That is one of the reasons why we have had to be extremely proactive in promoting opportunities in social care. For example, we will, I hope, be involved in international recruitment. We are trying to look at every opportunity. That is, in part, a reflection of the cost of living.

**The Convener:** We will move on to workforce issues later in the session.

Emma Harper has a supplementary question on that issue.

**Emma Harper (South Scotland) (SNP):** Good morning to youse. My question is about working with the third sector as part of winter planning, so I am sure that David Gibson will want to come in. Nicky Connor mentioned that we need to plan widely and collaboratively. What work is being

done to involve the third and voluntary sectors as part of winter planning?

**Nicky Connor:** Our third sector lead is part of my management team, and the purpose of that is to support open discussions. They sit on the extended leadership team, too. I have also created an integration leadership team that brings together up to 200 people across the third and independent sectors as well as our statutory services. We meet regularly to talk about issues that matter to us collectively. That feels like change and progression in terms of supporting integration.

I hugely value the role of the third sector. One of the services that we are engaging with is the Well in Fife. We are looking to establish a Well service in each of the localities. Communities can be signposted to that point of contact by other services or they can go to it by themselves. That has a lot of third sector support. The data that it provides enables us to identify community priorities and how we best use that information. In addition, we have groups in each of our localities that have third sector representation, which shapes and influences our work.

**The Convener:** Dr Loughrey wants to come in briefly on that point.

**Dr Loughrey:** To touch again on the impact of deprivation on utilisation of services, the deep-end GPs group has written a lot about the funding and primary care additionality that is required for looking after patients in those circumstances to meet their healthcare needs and to try to reduce the impact on other services. We know that patients from the most deprived populations are greater users of both primary care and emergency departments. That is not inappropriate, because they have more complex and greater healthcare requirements.

Dr McHenry, who is one of my colleagues, recently published work examining the association between deprivation and ultra-long waits of more than 12 hours in emergency departments. That found that patients from the most deprived backgrounds are facing longer and longer waits in emergency departments—the association between the two is clear. Therefore, it is a truly whole-system problem. Patients from the most deprived communities not only require more healthcare from their GPs and emergency departments, but are receiving a poorer healthcare experience and facing an increased risk when they come to our doors. That is another example showing that a whole-system approach will be required not just for this winter but for planning for the next five to 10 years.

Yes, we have an ageing population, but we need to get to the bottom of how we address equality in healthcare and make sure that patients from our most deprived communities receive care that is equitable with that which is received by those from the least deprived communities.

**The Convener:** I think that David Gibson wants to come in.

**David Gibson (Social Work Scotland):** Apologies, convener, but I do not seem to be able to use the “raise hand” icon or to read messages.

Exactly as my colleague just said, we must look at taking a whole-system approach. The third sector is key to that. However, one thing that must be pointed out is that, when serving rural and island communities, we are often robbing Peter to pay Paul. If the third sector is successful in recruitment, they will have come from us. It is also more than likely that the public sector and the NHS have taken staff from the third sector.

We have a fundamental problem—we do not have enough people to look after all the people—so we need to ask how we can do things differently. To pick up on what John-Paul Loughrey said, fundamentally, we have to take a whole-system approach and get away from short-termism and even from the concept of winter planning. Those system pressures are endemic. We do not have enough social workers or social care workers. You mentioned that we will come on to talk about the workforce, convener. The workforce is the key restriction as we move forward. As one of my other colleagues said, it is not just about recruitment, because there are not enough people to recruit; it is also about training and so forth. I apologise for drifting into talking about the workforce; when we talk about the workforce, I would be happy to come back to that point.

**Paul Sweeney (Glasgow) (Lab):** I thank the witnesses for coming today. Submissions in response to our call for input to our inquiry cited a disproportionate focus on secondary care in the most recent winter plan and claimed that it undermined the Government’s intention to support a whole-system approach. Indeed, health expenditure across the UK is similar to that of other Organisation for Economic Co-operation and Development countries in total, but differs in that most of the spend is allocated to hospital care as opposed to preventative care or community-based settings. It could be argued that the disproportionate expenditure on secondary care is a year-round structural imbalance that exacerbates vulnerabilities, particularly in the acute hospitals.

Do the witnesses agree with the views expressed in written evidence that primary care was not prioritised in the winter plan in the way that it should have been? Perhaps you could pick

up on the point that John-Paul Loughrey made about GPs in deep-end practices?

**Pamela Milliken:** Although we got instructions that informed our winter planning—as Nicky Connor alluded to—we work as a whole system. As health and social care partnerships, we bring to the table what is important to us in relation to winter planning. We do that collaboratively. We are aware that the acute services will be looking at how they can maximise their capacity. We all came together and looked at our whole capacity. For example, we have community hospitals and we looked to maximise and improve the number of surge beds. We also have various sheltered housing and care homes that we run in-house and we looked to increase the number of places there, too. We also explored where we could commission additional support and put in key staff; for example, we increased our staffing in the discharge hub in acute services. Some of that was done with the winter moneys that we got a couple of years ago but only started to have an impact last year because it took a period to recruit.

We work as a whole system to maximise how we work together as a community, including primary care. I talked about anticipatory care plans. I am aware that people spend the majority of their time in the community, so the more we do around prevention and support in the community, the more people will not have to go into hospital—as others have commented, hospital can be the wrong place for people to be and is certainly the wrong place for those who are waiting there because of delayed discharge. We have other initiatives such as the virtual community ward, which is our equivalent of hospital at home and aims to prevent people from being admitted to hospital. That is additional support that we put around the GP practice for people who are likely to get admitted. Recently, we were asked to put a bid into Government to expand that capacity. There is mileage in additional support and capacity in the community—we could avoid admissions, support people better at home and do more preventative stuff.

As I have said, we are trying to get the best workforce we can get, given the resources that we have. We know that things are tight—we are tight in resources this year and we are tight across the workforce. However, we try to use people to best effect. That includes the third sector, for example. Ours is a place-based locality response to make a difference: we can build on our places and localities—we are starting to be part of place-based planning, which is about working with the third sector, the council and communities—to try to build resilience and local responsiveness, so that the statutory services have to intervene less. That needs to be part of our future response.

09:45

**Nicky Connor:** I will build on what Pamela Milliken has just said. The sustainability of acute services is a key priority for our partnership, in line with the priorities of Health and Social Care Scotland. The role that we have involves using alternative pathways to ensure that people who do not need to go to hospital do not do so, and, when people do need to go to hospital, supporting them to be discharged as quickly as possible. On some of the work that has gone on around that, I echo what Pamela Milliken said about the hospital at home service. We have also put in a bid in recognition of the fact that respiratory conditions are one of the causes of admissions over winter. That is an area in which we believe we could do more, and we have set out a proposal around that. We are also doing work around urgent care to identify people's needs, with regard to flow and navigation.

Similarly, like all partnerships, we take a locality-based approach. We have identified one of our localities where there are higher admissions to our emergency department, and we are doing a whole-system huddle to examine the needs of people in such communities and how to respond to them. We are also doing work specifically with the Scottish Ambulance Service on support for mental health. A range of work is going on in various areas, and prevention is the key.

The other thing that is important is that we should consider not only discharge from hospital and prevention of admission but unmet need in the community. That area is critically important to us, and we monitor it and provide submissions on it every week. We also ensure that the individuals in the community who have an assessed need are accessing care. That is a critically important preventative measure. A significant amount of work has been done by health and social care partnerships to provide that balance across the system.

**Paul Sweeney:** I presume that that monitoring feeds back into the design of the services. However, trying to direct the immediate firefighting activity that goes on in an accident and emergency department towards building up that capacity might be a challenge. Dr Loughrey, do you have a view on the practical ways in which resource might be pulled out of areas in which there are people in crisis because they have not been dealt with earlier in their care journey?

**Dr Loughrey:** It would be remiss of me not to talk about the experience in primary care, and that of GPs in particular. You have probably read the submission from the Royal College of General Practitioners, which is deeply concerned about last year's winter plan and the on-going winter planning, which it describes as focusing largely on

secondary care. We know that around 10 per cent of GP practices have had to close their lists and that there is a workforce crisis in primary care. We also know that a lot of the strategies around the winter concern attendance and admission avoidance—trying to keep people at home—but that puts more pressure on already overburdened GP surgeries. The messaging seems to focus on people avoiding coming to emergency departments and going instead to GPs and pharmacies, which fails to recognise that those services are already experiencing huge pressure and that, when hospitals and health boards ask GPs not to send patients to hospital, that transfers a lot of the burden of risk on to the community.

On the strategy for the funding of our healthcare service, organisations have called for a national conversation, a longer-term strategy and a review of how all this is funded and organised. Undoubtedly, patients get better care when it is as close to home as possible and when they are in hospital for as short a period as possible. However, when we talk about flow in a system, we are largely focusing on flow from emergency departments and receiving units into hospitals and out into the community; rarely do we focus on the flow back into primary care of some of the complex work that has traditionally been done in secondary care but is increasingly being performed by GPs. We know that emergency patients' cases are becoming more complicated. Previously, 10 per cent of patients presenting to emergency departments were considered to be complex cases, but now that is around 30 per cent. That experience is borne out in primary care, where our GPs and their colleagues are dealing with more and more complicated problems, often for longer periods because of increased waiting times for outpatient clinics and elective procedures. If we have a winter like the last one, with swathes of elective care cancelled in the short term in order to respond to acute pressures and crises in the emergency care system, that will simply delay care and lead to long-term complications for some of those patients.

There is no significant strategy for the winter that would considerably increase the capacity in primary care, but we need a longer-term strategy to help our colleagues in primary care and general practice to respond to the needs of our population and to resource them to do that so that they can do what they do best, which is manage complex long-term conditions and have long-term oversight of the care of their patients.

**The Convener:** We need to move on. I ask MSPs to ask short and concise questions and witnesses to give short and concise answers, because we still have quite a bit to get through.

**David Torrance (Kirkcaldy) (SNP):** Good morning, everyone. To what extent does the existence of all-year-round pressures now make the concept of winter planning redundant?

**Pamela Milliken:** I will give a quick answer. Nicky Connor and I have said that the pressures are all year round. There will be particular pressures in the winter. We will get increased levels of flu, which will require vaccinations, and respiratory illnesses. We will also have weather incidents that will cause falls. We know that, normally, January and February are potentially even more pressured, but you are absolutely correct that the pressures are all year round.

**Nicky Connor:** I agree. We need 365-day planning. Within that, there are different peaks and troughs and different challenges at different times of the year. Some of the challenges are over the public holiday period. We face such challenges in the middle of winter, but we also experience them at Easter. The planning that we did for how we support the system in both those periods this year was no different.

**David Torrance:** The committee has heard evidence that the 2022-23 winter planning and associated funding came too late. If policy makers intend to continue with the creation of an annual winter plan in the future, how can the timings for its development be improved to accommodate the needs of different professions?

**Pamela Milliken:** The main funding that came to health and social care partnerships was the interim beds funding that came in January. That was helpful for getting that provision up and running for the winter period, but it only built on any plans that we already had in place for interim care beds. It allowed us to expand capacity, which we did. We found the funding useful. We had invested in interim care, which meant that we could just build on it.

However, it makes a difference if the investment is much more planned and sustained, because, to be effective, we need to be able to recruit teams, embed them and get the systems working well. Funding is always supportive and we are in challenging times at the moment, but it is much more effective to have it further in advance.

**Nicky Connor:** I agree. It is about that. We need to plan in the medium to longer term. However, we are talking about diversity of need across the system. It can often be helpful to know that funding is coming and that it is targeted on specific areas, but it must also come with local flexibility. Across Scotland, there are 31 health and social care partnerships, all of which are different. When we consider different organisations and needs, whether in primary care, social work, social care or the third or independent sector, it can also

be helpful to bring forward funding with the requirement to focus on areas.

**David Gibson:** We need to get away from winter planning as a concept, because the pressure is all year round. When we talk of winter planning, we get into short-termism and planning for a few months ahead. We need to plan for not just the next year but the next five or 10 years, because we cannot develop the workforce and services with short-term funding that is provided almost on an emergency basis.

I will put on my Argyll and Bute hat, although that is not why I am here. When we get short-term money, it is almost impossible to recruit for short-term posts in our rural and island areas. No one will move to an island or some of our most remote areas for a six-month or three-month contract.

Short-term planning and funding are damaging the system. Money is not the main restrictive factor any more—people are. Therefore, we have to consider how we get those people in place. That is a four or five-year plan; it is not even a one-year plan, never mind a plan for the next three months.

I very much take your point into consideration, Mr Torrance.

**Emma Harper:** I am interested in the national treatment centres in relation to winter planning. Pamela Milliken mentioned that, after people fall on ice, they occupy an emergency orthopaedic bed space. The national treatment centres are intended to keep bed spaces sequestered for elective approaches. The NHS Golden Jubilee National Hospital site has the national eye centre, and Fife has the orthopaedic centre. Will such centres help with planning organised approaches to beds in secondary care?

**Nicky Connor:** Some of the value of such centres comes from the regional approach. We are all part of regional networks and we plan together across the regions—we look from what is done in a locality up to what is done across Scotland and what is done in regional units. The value from that comes from planning together.

We must recognise the distinction between emergency medicine and planned medicine and recognise that different responses are required, because one is more predictable than the other. That can be incredibly challenged over winter, particularly if pressures increase on emergency medicine.

**Gillian Mackay (Central Scotland) (Green):** Good morning. Submissions highlighted that it can be difficult to recruit staff to short-term contracts to address winter pressure, particularly given the cost of living crisis and the uncertainty of such contracts for on-going employment. Given the earlier comments on planning for 365 days rather than in response to short-term pressures, how can workforce planning and the models that we use be improved to give staff security and recruit staff according to future needs?

**Pamela Milliken:** Recruitment is a challenge across all our services in Aberdeenshire, particularly in rural areas. As individuals have said, potential staff need to come from the areas involved or be attracted to move back, so we need to grow our own, going forward. We definitely need longer-term planning.

I touched on the fact that social care needs to be an attractive proposition for staff to come into. As is the case for other staff groups, people have had a stressful and challenging time. The number of our people who are off with stress is still relatively high. Across the whole gamut of social work, nursing, allied health professions, general practice and care management, we need to make careers attractive for people to come into and stay in.

We work closely with schools. We have an extensive number of foundation apprenticeships, and young people come into our facilities for work experience before—we hope—they take a career in health and social care. We have gone to recruitment fairs across Aberdeenshire to bring people back into the profession, and to attract new people. We also need to work with universities to look at career pathways.

A key component of my priorities relates to the workforce and continuous development. As we maximise integration, we also need to look at how we can use the skills that we have to best effect. How can we bring staff teams closer together? We have community treatment and care nurses and we have vaccination staff, for example. If we look at who does what, can we maximise their input into the community? A similar question applies to our social care and healthcare support workers.

At every turn, we try to make best use of our staff. We also need to look at the career pipeline and make the place really attractive for people to come to work and stay.

**The Convener:** David Gibson has indicated that he wants to speak.

10:00

**David Gibson:** You caught me off guard there, convener—thank you.

As has been said, we have significant plans that will help us out in four or five years' time, and the phrase often used in that respect is "grow your own". However, although all of those plans will have benefits in three, four or five years, the fact is that we have a very distinct problem just now.

What should we keep doing as we have been doing it? What should we do differently? There is also the question that no one really wants to answer, which is: what should we stop doing? If we cannot increase the size of the workforce in the short run, how do we make the workload fit the workforce that we have? That is a really difficult question locally and nationally, but we have to address it, not avoid it.

**Nicky Connor:** There is also the issue of retention of staff. We are doing a huge amount of work on how we support our workforce—it is one of my passions, actually—because without them we are nothing. It involves not just our culture and the work that we do to support it, but some of the practical things that can also be done in that respect. For example, we have put up in every Co-op posters with a QR code that will, if you want to become, say, a carer, take you straight through to where you can find out how we support interviews and so on.

The question is how we make things accessible to people. We have established a care academy that is working with colleges in our local communities to develop career pathways, and when staff are with us, we have to look at how we support their career progression. After all, this is not just about growing our own at the point of entry, but creating careers in health and care.

**The Convener:** Gillian Mackay has a very short question.

**Gillian Mackay:** Submissions to the committee highlight significant concerns about staff wellbeing, particularly the accumulation of stress over repeated years, practicalities such as staff sometimes not having access to hot food and drink and, of course, the travel issues that social care staff face. What concerns do you have about the impact of winter pressures in that respect, and how is that being dealt with by your specific services?

**The Convener:** I will bring in John-Paul Loughrey to address that question, as he has been wanting to come in.

**Dr Loughrey:** I will keep it brief, convener.

It is a very pressing question. We have a problem with the way in which our staff are treated and the pressure that they are working under. We have a 6.2 per cent sickness absence rate in NHS Scotland, and that figure has been increasing during the past 10 years. According to last year's General Medical Council survey, trainees in emergency medicine are at the highest risk of burnout. Moreover, the GMC survey of GPs shows that they are also increasingly at risk of burnout and increasingly unable to provide sufficient care and that around 15 per cent of doctors surveyed have taken hard steps to look at leaving the NHS and medicine.

If we do not address the issue just now, it will take a generation to fix it. It does not take five minutes to train a GP or a specialist—it is something that we need a long-term and coherent plan for. Short-termism is not the answer. Last year, there was a reported spend of £450 million on agency staff in the NHS in Scotland, and that money could have been invested in the people who are in post just now. To do that, however, we need to look at parity of esteem and parity of pay so that, as David Gibson has said, we do not rob Peter to pay Paul. National treatment centres will have to recruit staff to operate in them from a finite group of people, and we are looking at NHS staff moving from the third sector and social care, perhaps because of a difference in pay. If we do not have a long-term workforce strategy that cuts across all of social care, healthcare and medicine, we will end up taking away staff who could be providing care in other sectors, without our having any long-term view of the unintended consequences of such moves.

**The Convener:** I call Tess White.

**Tess White (North East Scotland) (Con):** I have three questions, the first of which is for Pamela Milliken. Aberdeenshire health and social care partnership covers remote and rural areas where the future of primary care is in jeopardy. Indeed, as we know, Braemar has faced such huge difficulties in recruiting a GP that, in December, the practice will have to hand back its contract and move to a 2C arrangement. There are already six general practices under such an arrangement in your area and Braemar will make it seven. Given that increase from six to seven, do you expect the number to increase again in the coming year?

**Pamela Milliken:** The number is five at the moment.

**Tess White:** So it is an increase from five to six, then.

**Pamela Milliken:** Yes—we were able to return one back to independent practice last year. At the moment, we are out to tender for our 2C practices, and we have had some interest—

**Tess White:** Sorry, but my question is whether that number will increase.

**Pamela Milliken:** I hope that the number will decrease. Contracts for those practices are put out to tender in an effort to bring in independent contractors to take some of our 2C practices back into the independent sector. We are going through that process and are optimistic about where that will take us. I think that that will be helpful. As I said, we have recently been able to return one

practice to independent contractor status. I hope that we can minimise the number of 2C practices.

The Braemar practice is primarily a single-handed practice, having had its second GP retire. That means that we have a much shorter timeline. To keep services safe for individuals, we have to support that practice to withdraw within three months. Given the timeline, we can go out tendering for the practice, but because we need to ensure continuity of care, we plan to take it over. At that point, we can go through a tender process.

We are working very closely with the GP practice and the community to make sure that we can make health services as sustainable and supportive as possible during that period. If the practice is able to recruit in the meantime, that will be brilliant, because it will probably retain the contract. Otherwise, we can try to bring in a new practice.

Earlier this year, we had another example of a very large GP practice that looked to return its contract. Having had us get round to the practice with a team looking at its sustainability and how we could support it, it also reached out to other practices across Scotland and looked at their models. The practice was able to redesign itself to feel more confident, and therefore the GPs decided to retain their contract.

It is about constant and close joint working with the practice and the community when we have a practice that is unstable—

**Tess White:** So you do not expect the number to increase, and you hope that it will decrease. I will move on to my second question, because we have been asked by the convener to be quick.

You describe the issues that rural practices face because of bad weather, and the Braemar practice is a good example of that. You talked about high winds, flooding and heavy snow in the winter. When it comes to moving a GP practice to 2C status and the cost model of sourcing and supplying the practice with locums, that can work in-hours, but it cannot work out of hours, so you have rural practices that are cut off and isolated during the winter months. What are the cost implications of that, and what are the considerations of leaving those remote areas without any form of GP support?

**Pamela Milliken:** The Braemar practice is quite exceptional. It provides its own out-of-hours service, which is very unusual. In all the other GP practices across Aberdeenshire, out-of-hours services are provided by our Grampian medical emergency department service—GMED—so that provision clicks over. We will need to do work on that issue with the Braemar practice, and we are having a workshop later this month. We will also work with, for example, the Scottish Ambulance Service, because, as you say, Braemar is very remote and the practice has traditionally provided its own out-of-hours service. We will also work with GMED to make sure that Braemar has out-of-hours cover.

You are absolutely right that we require to provide both an in-hours and an out-of-hours service for the local population. We will look at what model will be effective in doing that. As you rightly say, there might be cost implications, but the important thing is to get the right care for the local community.

**Tess White:** Okay, thank you. My third question is a final one for Pamela Milliken. The Insch war memorial hospital's minor injury unit—minor injury units are very important, as we know—and in-patient ward closed in 2020 to allow nurses to be redeployed to other healthcare settings, and the hospital never reopened, despite the former First Minister committing to renewing or upgrading that community facility more than two years ago. What are the obstacles to reopening that facility? What is the timeframe for delivering on that commitment?

**Pamela Milliken:** I will need to correct myself if I am wrong, but I do not believe that I have had a minor injury unit, because it had already closed when I came into post and I have been in post for a couple of years. I will correct myself if I am wrong about that.

However, the physical infrastructure there is not appropriate for in-patient care because of the size of the rooms and some of the infrastructure. We are working very closely with Friends of Insch Hospital and Community to see what alternatives there are to that facility and how we can ensure that we have good community resources and support in that area. At the moment, patients from that area travel to neighbouring community hospitals if they need to stay in a community hospital. Every community would like to have its own local facility, but it is not possible to run in-patient services in that environment at the moment. We need to look at what we can do now to shore up and work closely with the community on what outreach or home-based services there could be or to build on virtual community wards and other ways of working more practically with people in their own homes. There was potential for a business case to be put through to the Scottish Government, but we all know that capital is extremely tight across Scotland, so we need to be realistic about that.

**Tess White:** That sounded like a politician's way of saying that it will not reopen. Thank you.

**Carol Mochan (South Scotland) (Lab):** My questions are on the theme of public messaging. Sometimes it is suggested that we need to

manage people's expectations of the NHS, but I worry about doing that. Based on the evidence that we have heard today and some of the discussions that we have had, I wonder whether Government needs to be more honest with the population about where we are with the NHS. Do you think that that message is out there in the public? In my experience, most people are only trying to access services in the same way as they have for many years.

**Nicky Connor:** There is an opportunity for us to reframe the conversation, and it is important that we do that. That means at the national level, through national comms, and at the local level. By their nature, national comms can only be broad, but local comms can help people to navigate to the right place in the system. There has to be synergy between national and local comms. Sometimes people get a little bit confused when they are directed somewhere and they go there but the place cannot meet their needs. We need to be clear about all of that.

There could be communications about the services that can be provided, and stuff can also be said through our public health messaging—for example, on the importance of vaccination and some of the measures that people can take to help and support themselves. There needs to be synergy between those national and local communications, and the time to reframe a conversation for the future is now.

**The Convener:** I think that John-Paul Loughrey wants to answer the question.

**Carol Mochan:** Yes—I particularly want to put the question to him. We put a lot of pressure on people about alternative pathways. I believe in them, but people have accessed services in the same way for a long time. Sometimes we put too much pressure on people—particularly those in the deep-end practice areas that you mentioned—to access things in a different way, but we do not help them to navigate that well. I would welcome your comments on that, Dr Loughrey.

**Dr Loughrey:** There is a really important point to address about public messaging. A lot of public messaging is about trying to get people not to access services when, in general, those patients—our friends and family members—are only trying to access services in the best possible way.

There are two areas to address. We have to be honest and tell service users and patients what they can expect this winter. It might be that some assessments are done virtually, using Zoom or other platforms, and in ways that are new to patients, and that might take a bit of getting used to. However, many conversations can happen virtually, especially in primary care. Colleagues in primary care want to address that and ensure that our patients and our population know that that is how healthcare will sometimes be conducted. It might be that we use our flow navigation centres more to pinpoint and redirect people to the best services for them.

On the measures about public health messaging, last winter, we saw astronomical numbers of patients present to paediatric emergency departments, GPs and paediatric services with concerns about the group A Strep epidemic. A lot of those people were "worried well" patients and parents who were perhaps on treatment and were not getting better as quickly as possible, but the public health messaging about that never really changed. Public health messaging has to be agile; it should be able to change to ensure that patients who could be directed to self-care do not overwhelm our services.

We need to tell people what the winter will look like and how they will be seen. Generally, people choose well. We are not deluged with people who should be seeing their GPs; indeed, very few patients that present to EDs—only around 10 per cent of them—should be seen by other services. GPs need support to say, "You don't need to be seen in person for this—you can self-care or we can see you virtually or by telephone."

On the point about planning for spikes in activity, asking people not to come to emergency departments and to see their GP instead is putting more pressure on an already overburdened area of the system when some of those patients might be better with self-care or with being seen quickly in the first place where they have chosen to seek their healthcare.

10:15

**The Convener:** Emma Harper has a brief supplementary question on that point.

**Emma Harper:** Thanks, convener. It is gonnae be brief. I am thinking about public messaging this winter to encourage folk to take up their Covid and flu vaccines because of BA.2.86—the new variant that people are worried about. Is more messaging needed out there to say that Covid isnae over and to encourage people to take the vaccine?

**Pamela Milliken:** Absolutely. We have had the announcement this week about the bringing forward of vaccinations to respond to the new variant. We have looked at our plans and we are able to accelerate that programme, particularly for people with complex needs as well as for our over-75s. We are looking to try to accelerate that programme to get people protected early.

You are correct to say that the more public messaging we can get to get people protected, the

better it will be. We will encourage our staff, too, because it is key that they be protected, not only for their availability but because we want to be really cautious and ensure that we keep everybody safe. Everything around that work will be helpful.

**The Convener:** We will move on to our final theme with some questions from Paul Sweeney.

**Paul Sweeney:** I want to touch on some points that are made in the written submissions about potential waste in the healthcare system. The most valuable commodity in the national health service is time, but Community Pharmacy Scotland reports in its submission that

"Community pharmacists did not have read and write access ... to the patient ... record"

so they had to email or write to GPs with details of any changes. That antiquated process is taking up pharmacists' time, and CPS says that it creates a "risk" in that patients might seek "further treatment" before their records are updated.

That is just one example. Other blockages came to light last winter that could be remedied with the support of technology. On the point about obvious waste in the system—CPS's view is just one that has been highlighted—do you find other examples of difficulties that would benefit from parliamentary support?

**Pamela Milliken:** We had a good news story last year in that we were able to get our care managers across our communities on to the hospital information technology system, which, by giving live records, allowed us to reduce the time for assessment from 15 hours to one and a half hours. You are absolutely right to say that more connectivity between records can save people's time. More investment needs to be made in information technology, in relation to both people's capacity to be more agile in how they are working and connections between the different IT systems that we have.

The community health index number replacement will make a difference because it will allow those back-office linkages between records, which will mean less duplication. Over time, support around digital technology has not been prioritised for our community teams. Areas of our staff still work on paper-based records, which is really not good enough, so we are working on that.

**Nicky Connor:** Without a doubt, it would be great for our systems to have that ability to talk to one another. The on-going getting it right for everybody—or GIRFE—pathfinder work is looking at integration. Moreover—this is not one of the areas covered by the pathfinders—we are, as I understand it, exploring transitions in care to bring forward some learning in that respect.

For me, the other area is technology enabled care. This goes back to the issue of public messaging. If we are going to deliver care differently, whether that is through video consultations or the use of sensor technology in people's homes to reduce the need for individuals to be responsive, we need to support people to understand and feel confident about the care that they receive in that way. It is an area that covers all parts of our lives—for example, we are much more digitally enabled when we go to the supermarket—and it should be expanding much more in our care sector. I guess that that will involve horizon scanning, looking at what works in other places and being able to bring that in.

The one thing that I would say about all these changes is that we need to have confidence in the ability of staff to use the product and in the public's ability to access the information in order for us to give assurance to individuals about the safety of their information. As a result, if we are going to do something different in this area, we need to invest in the roll-out and to support that to ensure that it is well implemented at a local level.

**Paul Sweeney:** That leads on quite well to my other question on the issue. I have heard, particularly from GPs in Glasgow, that people are so busy firefighting in their clinics day to day that their practices simply do not have enough time to consider innovations or improvements. That is a real frustration, because they know that digital solutions could help to alleviate some of the pressures that are facing primary care. The written submissions refer to digital care technologies such as NHS Near Me. Do any of you have views on how we can create a space not just to deploy technology, but to allow people to be trained and the technology to be embedded, particularly in primary care settings? I see that David Gibson has put up his hand.

**David Gibson:** The two examples that you have given are NHS or healthcare based, but the same frustrations and challenges are paralleled in social care and social work. Social Work Scotland carried out a bit of research called "Setting the Bar for Social Work in Scotland", which we have circulated to committee members, and it highlights that the number 1 frustration for social workers is the ever-increasing pile of paperwork, which is sometimes electronic and sometimes in paper form, and the interface between social care, social work and the NHS. As far as technology is concerned, as soon as we start, we almost become two organisations divided by the technology that we use. The points that you made do not apply only to the NHS; we find a parallel in the whole system.

**Dr Loughrey:** There are a number of things to highlight. First, there is the "once for Scotland"

approach. If we are integrating health and social care, we should start to integrate our healthcare records and communications. Our colleagues in general practice have rightly flagged up that, although the centre for sustainable delivery is looking at a swathe of "once for Scotland" pathways, they have had no representation with regard to the strategy in that respect and that, given that most of the patients originate in primary care and our communities, they should be involved in shaping those pathways.

My other point is a very simple one. The Royal College of General Practitioners is calling for protected learning and development time. As someone who might receive patients during that time, I find that that gives rise to a little bit of caution, but I think that, if we were to address the wellbeing and sustainability of work for our staff, such an approach would have myriad benefits for our patients in the future.

The time for quality improvement and for developing ourselves and our services arises when we are not patient facing. That time is important and it must be valued, but we have to plan for it in the future to ensure that it is sustainable and that patients are not left without access to any care. That might involve, say, offsetting, cross-covering or patients understanding that, on a particular day, they will see a different GP from a different surgery. The issue is the messaging and the management of that not just in primary care but in hospitals.

Having protected teaching and learning time that ensures that our medical and nursing staff are nurtured not just to develop their careers but to improve things for our patients is the only way that we can start to look beyond the firefighting that you correctly identified.

**Sandesh Gulhane:** We have been talking in exactly the same terms for a decade now. For example, John-Paul Loughrey might send me a letter from A and E on a Saturday, saying, "Can you please do these things for this patient, who doesn't necessarily need to be here?", but when the patient rocks up to me on the Monday, I will still not have that letter. We do not talk in that way.

Let me ask something more basic. When are GPs going to be able to do something as simple as repeat prescriptions without having to sign them in what might be a dangerous way? As a GP, I have to sign all repeat prescriptions, but I do not have the time to read them—no GP does. When can we have something really basic and simple that other countries have had for a long time, which is automatic repeat prescriptions?

**Pamela Milliken:** From my understanding, that might have something to do with the periods when people get prescriptions and support around pharmacotherapy, but I understand the frustrations that you talk about, given the scale of the activity that GPs undertake. From a pharmacotherapy point of view, we are trying to support that prescribing issue by having, for example, more patient reviews. In my area, it has been really challenging to get that pharmacotherapy workforce in place, and we have been able to put in only the basic level of the various levels of support that are identified in the new GP contract on pharmacotherapy.

You are right to highlight the matter, which involves not just the GP perspective on how we support people with long-term conditions, but also the patient perspective with regard to their ability to have regular reviews. I think that, if we were able to enhance the pharmacotherapy service, it would be supportive in that area.

**The Convener:** Thank you very much. We will have a short break as we change our panel of witnesses.

10:26

*Meeting suspended.*

10:40

*On resuming—*

**The Convener:** We continue on to our second session on winter planning. I welcome Caroline Lamb, who is chief executive of NHS Scotland and director general of health and social care at the Scottish Government; John Burns, who is chief operating officer and director of performance and delivery at NHS Scotland; and Angie Wood, who is interim director of social care resilience and improvement at the Scottish Government.

We move straight to questions, starting with Sandesh Gulhane.

**Sandesh Gulhane:** I thank the panel for joining us today. I will ask you exactly the same question that I asked the first panel. We in primary care do not have the ability to call a code black and say that there is far too much pressure; a GP partner's workload is unlimited. What are you doing to mitigate that and enable GPs to do more for patients than simply firefight and provide the basics?

**Caroline Lamb (Scottish Government):** I am happy to kick off on that, and I will also bring in John Burns, if he wants to add anything.

Your question is clearly much broader than winter planning and pressures—it is about how we support primary care throughout the year to provide the best possible service. Our focus has been on increasing the number of staff working in multidisciplinary teams around the GP to enable

the GP to be the expert generalist in the community. We have now grown those multidisciplinary teams to around 4,700 staff across Scotland, which means that on average—and it is an average—every GP practice has access to around five pharmacists, phlebotomists, physiotherapists or advanced nurse practitioners. That sits at the core of how we are trying to support primary care.

**Sandesh Gulhane:** Community link workers in Glasgow have written to me en masse to say that there are deep-end practices where community link workers are being cut. The meeting that I had suggested that some—a lot—of community link workers are considering their jobs, given the changes that might be coming down the road. If that is the case, how are we helping primary care if we are getting those deep cuts in our link workers?

**Caroline Lamb:** Community link workers are an absolutely integral part of those multidisciplinary teams, particularly in our deep-end practices. We are aware of the issues that have arisen in Glasgow, and the Scottish Government has provided additional funding in the current year to support those community link workers. We are continuing to look at how the primary care improvement fund is being used and how that funding is being prioritised to ensure that that really important service can be maintained.

**Sandesh Gulhane:** I turn to my final question. Recent statistics show that 820,000 Scots are on a waiting list. That leads to pressures not only on GPs, because people will come back to their GP, but on A and E departments, because everyone cannot get the help that they need from their GP, so they start going to A and E and the cycle continues, which makes things far worse. What are you doing to ensure that patients are seen in a more timely manner when it comes to referrals?

**Caroline Lamb:** I will give you a few headlines and then hand over to John Burns on that one. As you know, we have been working to reduce the very longest waits, and we have had significant success in that. We know that there is much further to go and much more that we need to do, so we have been working with our health boards and the national centre for sustainable delivery to look at how we can take advantage of all the productive opportunities and use the national treatment centres that are coming on stream. I ask John to add a bit more detail on that.

**John Burns (NHS Scotland):** As Caroline Lamb said, our focus is on working to support boards to reduce long waits and we recognise that as a key area of focus. We are also looking to discuss with boards the opportunities to address waits on our lists in totality.

We are looking at a combination of things. First, we are working with boards to find ways of improving, such as through the patient-initiated review, which looks at improving the experience of patients who might previously have come back for a review appointment so that they can take back some of their power. That initiative will also create capacity within our out-patient clinics.

10:45

That is one example. Other examples include looking at the advanced clinical referral triage, which means ensuring that, when patients are referred, we assess them and ensure that we send them to the most appropriate professional for their care. We have seen a significant positive impact as a result of the work that the centre for sustainable delivery has done. Quarter on quarter, the number of people who are being treated has been increasing since the pandemic. Through the work that we are doing in funding waiting lists initiatives to support boards, we are able to create some of that additional capacity.

As Caroline Lamb said, our national treatment centres came on board in Fife and Highland this year. We have capacity in the Golden Jubilee hospital and its second phase will come on board later this year, as will NHS Forth Valley. We are building capacity so that we can increase the level of care and the number of treatments that we can offer.

**Evelyn Tweed:** Our inquiry is looking at the effectiveness of last year's winter preparedness plan. How does the Government feel that the plan went? In this meeting, we have heard a lot about moving away from the notion of winter planning and moving to a whole-system approach. Is that something that the Government is going to do?

**Caroline Lamb:** Absolutely. We recognise that we need to focus on improving the systems year round, but there will always be points of surge and additional pressure. Winter has traditionally been one of those points because of the increase in the number of respiratory illnesses and because people have accidents because of adverse weather conditions. However, winter is not the only surge period. In the past couple of years, there have been Covid-19 driven surges outwith winter.

We recognise that we need to support the system to manage unscheduled care as effectively as possible throughout the year and to have the ability to deal with surges. We have reflected on the planning that we did last year and have learnt lessons collectively, having engaged others in the process. This year, the approach that we have taken has been to start much earlier and to engage in a whole-system planning approach.

I will give you some headline examples of that. We issued our "Delayed Discharge and Hospital Occupancy Action Plan" in March and have been building on that with local systems to develop improvements and deliver the things that we know make a difference, such as improving flow through our hospitals and working on data and our workforce. In August, we had our first ever winter summit, which was led by the Convention of Scottish Local Authorities and the Scottish Government. It brought together leaders from across health, social care, local government and the third sector—300-odd folk were there.

All of that has been part of our approach to winter planning, which is about accepting that the system is integrated and that we need to engage all partners. We need to ensure that there is an ability nationally to draw out good examples and produce guidance about what works really well. Local systems also need to be supported to plan collectively and to draw on resources across systems so that they can deliver and support people in an integrated fashion.

We have also ensured that we have whole-system oversight of our planning through a group that is co-chaired by an NHS chief exec, a council chief exec and a chief officer. We are working together on actions that will deliver improvement and on evidence of good work that we want to spread. That is another demonstration of how the way that we are working this year is different to the way that we worked last year.

**Evelyn Tweed:** As I said to the earlier panel, we are in a cost of living crisis and people are dealing with many issues, including heating their homes and fuel poverty. Are we thinking outside the box in relation to initiatives to stop people with those problems presenting to the NHS? I read about one initiative where doctors were prescribing heating to patients. We know that the health service does not work only as one thing. Are we thinking about all those other things that will help people to avoid becoming ill and presenting?

**Caroline Lamb:** We recognise the additional pressures and the additional burden of ill health that has been driven by the cost of living crisis that so many people have experienced.

As NHS and social care services, we provide apprenticeships and seek to bring people into well-paid employment. The community link workers who were referred to earlier are key in supporting people to access all the services that are out there. The chief officers in our health and social care partnerships have also been looking at preventative work to take forward. Angie Wood might want to give us some examples of that.

**Angie Wood (Scottish Government):** I am happy to do so.

Evelyn Tweed is right that we need to take a whole-system approach. As Caroline Lamb said, the chief officers are key to that, as are our local authority partners. Many of those issues are high on their agendas. There are a number of examples across the country, including in relation to link workers and other multidisciplinary teams.

Traditionally, we often think about those multidisciplinary teams as being purely about health and social care but, in many areas, they involve partners from the third sector who work with families who are experiencing poverty, as well as with housing providers. Innovative work is being done on how we can support people in those different environments in different ways. The whole-system approach is critical to the preventative agenda and the health agenda at the other end of the scale. Colleagues in Aberdeen city, for example, have strong links with many of those community resources, particularly through their community planning groups. The chief officers in the health and social care partnerships are key and critical to that.

Some of the work that we are doing around the preventative element is very much about trying to get into that space. We often go into a resilience place when we talk about winter, but we are trying to get into that preventative space so that we can identify productive opportunities. That is often the way that our teams, and primary care teams, work in their local communities. It is about making sure that our structures are reflective of that. In the experience of many of the chief officers, it is not only about how we can help with the pressures in the NHS but how we can help people to improve the outcomes that they are experiencing, particularly in that preventative space.

**David Torrance:** Good morning, everyone. Last year's winter plan was criticised for coming too late. It was published in October. When will this year's winter plan be published?

**Caroline Lamb:** Our plans currently are to bring the winter plan to Parliament in October. However, the difference from last year is the amount of work with systems that has already gone into developing that plan. There are no surprises for anybody in that plan. As I said earlier, we started the planning in March, coming off the back of last winter, with a clear focus on the actions that were necessary to improve flow through our hospitals. As John Burns described, we built on that through the system oversight group, which has had responsibility for seeking assurance from local systems around that.

Our winter summit provided an opportunity for everyone to engage in agreeing on the key things that needed to be in that plan. The publication of the plan is the last hurdle, if you like, but as I said,

there will be no surprises in it. Systems are already doing the work.

John Burns and Angie Wood might want to say a bit more about the winter checklists.

**John Burns:** Yes, I can add a couple of things to what Caroline Lamb has said. As has been mentioned, when it comes to winter, we need to plan throughout the year. Our unscheduled care improvement work, which is a continuous programme of improvement, is fundamental. Boards are continuously working on improvements that relate to flow through hospital, discharge and so on.

As part of our winter assurance work, we will issue a checklist for the whole system, not just the acute sector. That will enable boards to work with their partners on what the critical assurance points are so that we can assess where each system is as regards winter readiness. It is important that we engage early, because we need our local systems to do their planning in detail in the lead-in to the winter months. That earlier work has put us in a much better place to work much more participatively with partners.

**David Torrance:** Thank you. You have partly answered my next question. How do you respond to the suggestion that winter planning is now redundant because of the existence of year-round pressures, which require year-round planning?

**John Burns:** We all recognise that, as Caroline Lamb has mentioned, we get surges throughout the year. For example, we can have a busy time in the summer; it is simply a different type of demand on the system. That is why the work that we are doing to improve unscheduled care is essential in underpinning delivery of the improvement that we need to make on a system-wide basis to meet and support the care experience of people who use services 12 months of the year.

**David Torrance:** How will you ensure that winter planning accommodates the needs of different professions?

**Caroline Lamb:** Our starting point has been the level of engagement that we have undertaken with the different professions. As I have said, we have taken a whole-system approach. We have built on our learning using the relationships that we built last winter. John Burns might want to say a bit more about engagement with the health professions, and Angie Wood will be able to talk about the social care side.

**John Burns:** Clinical involvement in our work is central to our approach. With regard to how that focus relates to winter this year, the summit that we held a few weeks ago involved a wide range of participants, including clinical colleagues. We have also engaged with the Royal College of General Practitioners on the winter checklist in the plan to understand what it thinks is important in that regard. Members of the RCGP and the Royal College of Emergency Medicine were participants at the summit. We have deliberately sought to broaden participation in this year's plan and to be much more inclusive by taking learning from the work that was done last year.

**Angie Wood:** Our work with COSLA has also built on learning from last year. It has been a continuous process and I have not seen a step back from planning over the summer months. We have continued at the same level of activity and have maintained the cycles of improvement.

There has been close collaboration between the Scottish Government and COSLA and with other providers. You are right to mention the professional groups that we need to engage with, but there is also a huge range of providers out there. Some of that work is led nationally but, in other cases, close collaboration is being promoted at a local level.

We are very aware that there is so much variation across the country and so many different opportunities, so it is about what we need to do at national level and about how we can promote close collaboration at local level. I am sure that you would have heard from Fife earlier this morning about some of the real innovation that is happening there on collaboration. That reinforces the point about how we can do that at a local level to meet the needs of the population, but also have a different make-up of providers and contributors to help us prepare better for whatever surges come our way.

11:00

**Paul Sweeney:** It is clear from the submissions and the oral evidence that we have heard this morning that demand is at an unsustainable level and that simply inflating capacity, particularly in acute hospitals, is not an optimal solution. Relative to healthcare systems in other OECD countries, our expenditure share is much higher on acute hospitals and much lower in the primary care landscape.

How do we pivot to the fundamental restructure? How are you implementing a mechanism to monitor presentations in acute hospitals that could have been avoided had an intervention taken place in the community earlier? That could be as simple as providing heating for someone's house, some pastoral support or whatever. How is that analysis being undertaken and how is that informing service design? How are you then responding to pull the system into the place that it needs to be in? Demand management is the key challenge.

**Caroline Lamb:** I absolutely agree that demand management is critical, and that is fundamental to what we have been doing in how we use NHS 24. That is not just about the phone line system; it is about the online self-help guides that are available on NHS Inform and, increasingly, the app, so that people can support themselves and self-manage their health. We are using NHS 24, investing in multidisciplinary teams in primary care and seeking increasingly to manage demand. John Burns can give you some figures on where we have got to with all of that.

It is absolutely key to our response to ensure that only people who need to be in our acute sector are in that sector. That applies to people presenting and to admissions and, critically, it means making sure that, when people no longer need to be in hospital, they are supported to be returned to their home or to a homely environment.

Does John Burns want to say something about that?

**John Burns:** I can develop that a bit. I mentioned the unscheduled care work that we do. That programme has an admissions avoidance workstream, where we analyse data on length of stay and in particular on short stays in hospital to see what opportunity there is to redesign and deliver services differently. In recent years, we have seen the positive impact of hospital at home pathways around community respiratory services, of out-patient parenteral antimicrobial therapy and of hospital at home itself. That area has developed and grown and, from speaking to our clinicians about the opportunity for redesign, we know that it can deliver further growth.

That is about taking acute care into the community. Increasingly, as we look to redesign and address the demand challenge, that means almost removing the boundaries of hospital and community to ensure that the right teams deliver the right care in the right place. Hospital at home is a good example of that.

Another thing that we have found to be impactful is the redesign of urgent care and particularly the work that we have done on flow navigation. We are able to direct the process and often completely avoid an attendance at hospital through clinicians working in flow navigation, engaging with a patient—perhaps through Near Me—and determining the outcome.

The Scottish Ambulance Service has been doing important work on “see and treat” and “hear and treat” to ensure that, if an individual does not need to be conveyed to hospital, they are given the right care at home to avoid an admission. There is still work to do, and the admission avoidance pathway will be a key part of the continuous redesign that we will need to develop with our clinical teams in the months and years ahead.

**Caroline Lamb:** Given that the question was about capacity in the acute sector and how we shift away, it might be helpful for Angie Wood to say something about the work that we are doing at the other end of the hospital to ensure that we can get people out.

**Angie Wood:** Part of the demand is from people with complex needs, and particularly frailty, who come into our acute settings. They are often particularly susceptible to deconditioning while they are in hospital, which again increases demand and potentially increases the demand for social care. Obviously, the key and critical point is that that is not right for the person, either.

In many areas across Scotland—NHS Lanarkshire is a leading example—boards are investing heavily in re-enablement services and discharge to assess, which is key and critical. It has been reported that some people’s care needs can be halved when they are taken home to their own environment, assessed and supported there with a package of care that absolutely fits their needs and fits that environment.

People often adopt a different persona when they are in hospital. In many cases, professionals assume that a person needs more support than they need when they are comfortable and confident in their own environment. It is also the best thing for a person to feel that they are maintaining the maximum amount of independence that they can, while having continual review so that their support can be increased, should that be required. Some of the statistics that are coming through from NHS Lanarkshire, which has invested heavily in its multidisciplinary teams to do such assessment, are really interesting.

There is definitely something that can be done at both ends to absolutely prevent presentation where we can and to reduce the length of stay, particularly for frail and vulnerable people, so that we get them back into their own environment—whether that be a care home or their own home—with support. We can assess them in that environment and get the care package that is absolutely right for them.

**Paul Sweeney:** You mentioned NHS Fife and the example in NHS Lanarkshire. When there are examples of good outputs being achieved and clear evidence that they reflect good performance, how does the system or the span of control at the Scottish level capture that and normalise it across the health board territories? There is quite a cluttered landscape—shall we say?—of management structures.

**Angie Wood:** We are doing that work on a number of levels. Purely from a performance perspective, we have made significant advances over the past year in the amount of performance data that we can reflect back to the system. We have worked really hard with partners to put in place data-sharing agreements so that we can reflect back performance. At a local level, the position was quite difficult. Areas could see their own performance, but benchmarking themselves against other areas was perhaps more complex. We are now rolling that out, and it will be in place for this winter. Local areas will be able to have that level of scrutiny not just of their performance but of how other areas are operating.

John Burns referred to the whole-system oversight and planning group that we have in place. It is co-chaired by local authority and NHS chief executives and chief officers. They are taking the lead role in identifying that good practice.

Perhaps what we need to do is link up that improvement and performance and ask what that would look like in local areas. Local control over how areas commission and arrange their services would remain, but we need to highlight what such good practice means for people in terms of outcomes and then start to ask questions about that.

Sharing of good practice is absolutely happening; that is clear to see across Scotland. Maybe we need to probe the "So what?" question at a local level, so that that level of scrutiny happens to help inform decision making and commissioning.

**Emma Harper:** Good morning to panel number 2. I will pick up on what John Burns said about national treatment centres. Pamela Milliken, who was on the previous panel, said that winter planning includes having to think about slips and trips on ice, which can lead to orthopaedic injuries for which people need emergency surgery. However, the national treatment centres are for elective approaches, such as tackling ophthalmic or orthopaedic issues and performing upper gastrointestinal endoscopies.

John-Paul Loughrey, who was on the previous panel, said that staffing those centres would be like robbing Peter to pay Paul. However, my understanding is that our First Minister, when he was Cabinet Secretary for Health and Social Care, said that 1,500 additional staff would be used for the centres. Can you give us an update on whether we will be robbing Peter to pay Paul? What is the status of the recruitment of new staff for the centres?

**John Burns:** We have recruited additional staff to the national treatment centres that have opened. We have been able to recruit across all disciplines in order to open those centres. What is important in doing that is to integrate those staff so that they are not simply standing in isolation from the wider board team.

That approach enables us to protect planned care in the system. I do not have the exact numbers that we have recruited to, but that recruitment of additional staff was central to us opening the NTCs, and we funded that through the NTC programme.

**Caroline Lamb:** We can certainly write to the committee with an update on that.

**Emma Harper:** Because of my background in orthopaedic surgery and working in the operating room, I am curious about the flexibility of staff and the ability for them not to work in isolation. It is important that people know that we have the national treatment centres with the goal of challenging waiting lists for hip or knee replacements and ophthalmology, for instance.

**The Convener:** The previous panel expressed concern that the short-term or targeted funding that often comes for winter resilience initiatives poses challenges for health boards—particularly rural and island health boards—with regard to short-term contracts for staff. I am keen to hear whether the Scottish Government has recognised the challenges that are posed by that short-term non-recurring funding and whether there are plans to move away from that model, given that you have acknowledged that, although winter planning is one thing, the healthcare service and social care face challenges throughout the year because of different variables.

**Caroline Lamb:** We absolutely recognise the challenges that are associated with that short-term funding, in particular around the inability to recruit staff on permanent contracts and the likelihood that that will lead to higher staff turnover and that we will not build the necessary capacity as a result.

Whether it is for winter resilience or planned care, we have this year—as one way of trying to alleviate the pressures on our boards—increasingly moved, wherever possible, towards making allocations to our boards recurrent rather than non-recurrent. That will continue to be a work in progress, to try to ensure that we are baselining the funding that is needed, whether that is—as I said—for planned care or for supporting a really solid unscheduled care system. We are absolutely taking that approach.

**Gillian Mackay:** What assessment has been made of the impact of upcoming winter pressures on staff wellbeing, morale and resilience across health and social care? We have had several years of very high pressure, and that is not going to let off any this winter, even if we have a winter

with relatively mild weather in comparison with a bad winter.

There are significant concerns. What action can be taken to address that, such as bolstering wellbeing support and practical support on meals, breaks and other things? Does the Government expect a higher rate of turnover as a result of winter pressures?

11:15

**Caroline Lamb:** We assess and monitor that. We monitor staff absences regularly and we can use the iMatter survey to assess how people are feeling, particularly in our NHS boards. The situation is more complicated in social care because of the range of employers.

We continue to support staff wellbeing initiatives, which are incredibly important to us. At the national level, we have the national wellbeing hub and the psychological interventions, and we ensure that local boards continue to support some of the simple things, such as staff being able to access hot food and a drink through shifts. That is still a key part of our approach.

We will always have staff turnover; we are a very big employer, so high turnover is always expected. However, we see peaks and troughs. Yesterday, I visited NHS Ayrshire and Arran, whose newly qualified nurses are coming into the workforce, so the workforce shifts during the year as well. The Scottish Social Services Council has published encouraging statistics today on the social care workforce. You might want to ask us questions about work that we have been doing on that, but it is good to see the impact start to feed through in the statistics.

**Gillian Mackay:** As a Central Scotland MSP, I have a particular interest in NHS Forth Valley and NHS Lanarkshire. Given some of the pressures that those health boards have faced—in A and E in Forth Valley and across the board in Lanarkshire—has any extra thought, resource or anything else been put in place for such health boards that have particular issues? I cannot imagine the damage that the number of times that NHS Forth Valley's A and E statistics are reported on the news does to the morale of the staff who are working flat out to ensure that patients are seen, and that is without us being in winter-pressure territory. Given that pressures are more universal now, is resourcing going into, and is thought being given to, health boards that have particular issues?

**Caroline Lamb:** Yes—absolutely. We recognise that all health boards are in slightly different positions because of their localities, the needs of their local population and their footprint—how much space they have. John Burns can say a bit more about our national support teams, which go in and help boards. We talked about unscheduled care improvement work, which is about helping staff and teams to focus on improvements. Sometimes, in the heat of the moment, it is hard to think about things that could be done to improve the situation.

**John Burns:** The unscheduled care improvement team that sits in the centre for sustainable delivery works with all our boards to support and help them with their improvement plans. It is incredibly important that the improvement plans are owned by the local systems, but we are there as a critical friend to provide learning, share best practice and, where we can, give boards additional capacity through analysis or support for the work that they are doing.

As Caroline Lamb said, every board is different, so we provide different levels of support depending on need. We work closely with NHS Forth Valley on improvement work not only for the emergency department but on the flow-through and on supporting the team there to drive improvements. NHS Lanarkshire has its detailed operation FLOW, which is a whole-system programme. We can see the leadership and the way in which NHS Lanarkshire is implementing that in an inclusive way with its teams across NHS Lanarkshire and across social care. That is a good example of whole-system working.

**Tess White:** I have three questions, the first of which is for Caroline Lamb. You said that you always expect a high turnover of staff. As a fellow of the Chartered Institute of Personnel and Development, I know that, with regard to the percentage of voluntary staff turnover, there are what are called red-zone levels, and it looks as if the NHS is in the red zone, with staff turnover being too high.

Last month, it was reported that doctors in NHS Grampian had used whistleblowing procedures to raise very serious concerns about conditions and staffing levels, with one doctor saying that, tragically, that

"There have been avoidable deaths"

as a result of the situation. What action is the Scottish Government taking with NHS Grampian to address staff shortages urgently, especially as winter approaches?

**Caroline Lamb:** We always expect to see turnover in an organisation of the size of NHS Scotland, given our demographics, the age of staff and the number of new trainees and newly qualified staff coming into the system every day. With regard to overall staffing, I point out that the numbers of A and E consultants in Scotland have tripled since 2006. However, despite those huge

increases in the number of consultants, we recognise that we still have some issues, particularly with middle-grade staff.

John, do you want to say something about the support that we are giving to NHS Grampian?

**John Burns:** We have recently worked closely with NHS Grampian and facilitated a support visit with the Royal College of Emergency Medicine and other clinical colleagues to find out whether there was any further advice that we could give to support colleagues in Grampian. There was an opportunity for the visiting team to engage with the clinicians in the emergency department and other parts of the system and to point to any recommendations that we thought that NHS Grampian might be able to take forward. Of course, central to that is the importance of communication with all colleagues and teams.

In addition to the specific issues that NHS Grampian is facing, I know from speaking to the medical director and the chief executive that the health board is engaging with clinical colleagues in the department and is working through the best arrangements for providing that cover, recognising some of the challenges that it faces in that senior middle-tier rota. It is continuing to work on putting in mitigation in order to ensure that services are safe, and we will continue to stay close to NHS Grampian with regard to not just the visit that we facilitated, but the actions that it is taking to try to improve on the issues that you highlighted.

Beyond that, it is important that, in speaking to Grampian, we also think about whether there any wider issues that we need to address, and we are engaging NHS Education for Scotland in those discussions.

**Tess White:** My next question is probably best put to Mr Burns, too. How confident are you, going into the winter, that staffing levels are right? Where on the scale from nought for not confident at all to 10 for extremely confident would you put your confidence levels?

**John Burns:** Your nought-to-10 question is difficult to answer, but I would say that, from the engagement that we have had with all our systems across Scotland with regard to their service delivery and workforce, we can see that every board in Scotland is ensuring not only that they have the right staffing levels but that, where they have vacancies, they are looking at what actions they are taking to meet those gaps as we go into the winter. As Caroline Lamb said, there will always be vacancies through natural turnover.

That is where our winter checklist comes in. It helps us to seek from each system the level of assurance that it has with regard to its readiness.

**Tess White:** You have not really answered my question about your confidence levels and where on the scale you might be in that respect. Are you confident or are you concerned?

**John Burns:** I do not think that anyone can say that we are completely confident that everything with regard to the staffing levels at every board is where we want it to be, but we have a level of assurance from the work that our boards are doing on their readiness assessment for this coming winter. However, we recognise that, within that, there will be challenges for different boards.

**Tess White:** My third question is for any member of the panel. It is clear that the incentives to attract GPs to rural and remote areas are not enough to fill GP vacancies. What assessment has the Scottish Government made of the financial incentives that are available, the difficulties for GP recruits in accessing housing, and projects such as “Rediscover the joy of general practice”, in contributing to the sustainability of primary care in remote and rural settings?

**Caroline Lamb:** On recruitment to general practice as a whole, we were pleased to have filled 100 per cent of our training posts in general practice this year. We had really good fill rates across our entry training grades. That reflects the efforts that we have put into increasing undergraduate training places and programmes such as Scottish graduate entry medicine—ScotGEM—which are designed to attract people who want to work in general practice and who may also be interested in working in remote and rural areas.

I am not going to say that we think that we have completely cracked that yet. As you will be aware, we have additional bursaries to attract people into areas where, traditionally, it has been hard to recruit GPs. I do not have the numbers in front of me, but I can supply them to the committee. Those have been pretty well taken up. There are also additional incentives for deep-end practices. I do not have an assessment of the “Rediscovering the joy of general practice” project, but we can come back to the committee on that.

**Tess White:** It would be great if you could do that. Thank you.

**The Convener:** Staying on the subject of staffing, recruitment and retention, I note that research by the Nuffield Trust that was published in November 2022 found that Brexit had worsened the UK’s shortage of doctors in key areas of care. It suggests that about 4,000 European doctors have chosen not to work for the NHS. Separately, data that was released by the Nursing and Midwifery Council last May found that the UK has 58,000 fewer nurses than it would have had if the numbers arriving pre-Brexit had continued.

Are we seeing the effect of that on our NHS in Scotland? What, if anything, are you able to do to attract European Union nationals to come back or to come to work in the UK and in Scotland in particular?

**Caroline Lamb:** I have a couple of points on that. Anecdotally, we think that there has been an impact, not just in the NHS but in social care. However, I am not aware of any statistics that relate to Scotland in particular. I will check whether there are any and come back to the committee on that if there are.

On what we are doing, we have recognised that we need to look at international recruitment. We are now up to just over 1,000 international recruits to nursing, midwifery and allied health professions. There are some challenges in providing housing for those recruits. However, I heard some positive stories in Ayrshire and Arran yesterday about how the health board is supporting international recruits in temporary accommodation while they find housing and enabling them to orientate themselves in their new local environment.

We have also been keen to look at the opportunities for international recruitment in social care. We commissioned NHS Education for Scotland, as part of the work of the centre for workforce supply, to look at how we can support employers in social care to bring in international recruits. That is quite complex compared with the situation in health because of the number of employers that are involved in all of that. A pilot is now under way and we expect the first cohort of about 50 social care staff to come in by the end of March 2024. We hope that we will be able to build on that.

We have also been looking at what more we can do to recruit locally in Scotland. We have engaged strongly with the Department for Work and Pensions, and Angie Wood might want to say a bit more about the DWP job fairs. There has been some good success around that.

11:30

**Angie Wood:** We worked with the DWP to look specifically at what resources it could offer to work with us on that. It has delivered around 25 specific careers fairs across the range of employment opportunities in health and social care. Currently, more than 500 people who have been specifically supported through that have been offered interviews in various parts of health and social care in Scotland. We are continuing that work to look at how the DWP could work with us to support people who are not quite ready for employment and get them to that point.

Another important point is that people who work in health and social care are really valuable in the labour market. Often, we find, they develop core people skills that are wanted in other environments, so we are doing a lot of work on various pathways—

**The Convener:** That answer has gone a wee bit off the question. My question was specifically about the EU. We will move on to questions from Paul Sweeney.

**Paul Sweeney:** The written evidence suggests that the rate and frequency of the reporting of performance data has been a challenge and that the process for feeding data back is labour intensive. Has any consideration been given to how that process could be streamlined so that pressure on staff can be reduced?

**Caroline Lamb:** Absolutely. We are focused on minimising the additional demands that we put on systems during the winter periods in particular, but overall as well. There was a reference to the dashboard approach that we have been taking to enable our health and social care systems in particular to see their data and compare it to that of others. We have worked with partners so that everybody understands what the data requirements are and, where possible, we have tried to ensure that we pull data from sources that are already available to Public Health Scotland rather than looking to have people return separate sets of data to us. We are conscious of the need to minimise that data burden.

The same goes for our health boards. Increasingly, we look to ensure that we can pull data from common sources, rather than seeking to get people to submit things to us.

**Paul Sweeney:** A number of the written submissions question how data from previous years has been used to evaluate the impact of winter planning and identify gaps and opportunities for improvement. It is clear that there are multiple concerns regarding last year's plan alone.

One of the recommendations in the submission from Public Health Scotland and the Scottish directors of public health group is to

"Stop things that have not worked and not introduce anything that has not been evaluated in a robust way".

Ahead of this year's plan, has the Scottish Government undertaken any assessment of what has and has not worked well in previous winter plans? Can you highlight some examples?

**Caroline Lamb:** We absolutely went into the process of planning—which has, as we have described, been pretty continual—seeking first to learn the lessons from last year. That has probably been more about our approach to planning, but it leads into some of the concerns that were expressed by Public Health Scotland. Engaging

partners from the get-go in what we are planning and what we think will make a difference means that we are drawing on the best available intelligence about what will actually make a difference. We are then able to evaluate that.

For example, although the work that we put into providing interim care home beds last year has absolutely had an impact on the take-up of those beds, we need to reflect on the extent to which some systems were able to move people on, out of those beds, in order to release that capacity. Through working with our partners much more closely to understand what will make a difference and what has been tried and tested—this goes back to the question about how we spread good practice so that people understand which things work—we have emphasised much more the importance of focusing on the things that we know to work and bearing down on those things in individual systems.

**John Burns:** We always do a lessons-identified exercise, and what was fed back to us was that our priorities were the right ones. There was strong support for them. We have touched on many of the other things, including starting planning earlier, involving the whole system and the importance of data, which we touched on a moment ago.

We have worked closely with Public Health Scotland on data and reporting. We have made significant progress with our approach this year, and the work that we are taking forward through the unscheduled care programme has an evidence base. We are moving forward with things whose impact is shown by evidence and, where we do not see something showing that impact, we will change tack. The point has been made that it is right to build on a strong evidence base and do things that work and have impact.

**Paul Sweeney:** Is there a particular instance that springs to mind that might illustrate that point for us?

**John Burns:** Are you asking for an instance of something that we have stopped doing?

**Paul Sweeney:** Yes.

**John Burns:** Nothing springs immediately to mind. The unscheduled care programme has an evidence base because we want to ensure, before we go into things, that we are putting our resources and effort into the right things. The lessons were more about processes and planning and, as I said, we have made a significant improvement in our approach this year.

**The Convener:** Tess White and Emma Harper have brief supplementary questions.

**Tess White:** I have a brief practical question. You talked about a programme to hire 50 GPs. I am thinking particularly about the issues that are faced by rural general practices. We know about the example of Braemar, where the practice is trying to find a GP and it is looking globally. The staff are having to do all the recruitment work themselves, including organising visas. Is there a Scottish Government programme that could help them, or could the health and social care partnership do that for them?

**Caroline Lamb:** I am not familiar with the detail of that example, but NHS boards run a programme because we recognise that applying for visas is really complicated. Part of the infrastructure that is supported and funded by the Scottish Government is there to give each NHS board someone who is an expert in that sort of stuff. There may be a question about how individual practices can link up with those centres of expertise.

**Tess White:** Thank you. The committee will take that away.

**Emma Harper:** My question is about bursaries for people who are studying to be paramedics, nurses or midwives. I am a member for South Scotland and the border is 30 miles from Dumfries. Are we tracking whether the bursary that is available for people to study to be nurses or paramedics in Scotland, which is not available for people studying elsewhere—although it has recently been introduced in Wales—is encouraging folks to come from south of the border to train in places such as the University of the West of Scotland?

**Caroline Lamb:** I will have to get back to the committee on that. The Scottish Funding Council is responsible for monitoring the overall numbers of student paramedics and nurses in our system. We would need to check what data it has about the country of domicile of students who take up those bursaries. It is also important to track where those students go afterwards. NHS Education for Scotland has a mechanism for tracking where students who study at the University of the West of Scotland go into employment, so we can track that.

**The Convener:** We move to questions from Carol Mochan.

**Carol Mochan:** I am interested in knowing about how we support the public with messaging about the situation in NHS Scotland. We discussed public messaging with the previous witnesses. What is the Government's plan for the winter and the longer term? What will be the message about access to the NHS in Scotland?

I have a particular interest in alternative pathways, which I am very fond of. They are a good thing, but it is unrealistic to expect people who have done things in a certain way for a long time, particularly when they are under pressure

because of their own or a family member's health, to understand those pathways. What plans do you have in place?

**Caroline Lamb:** We absolutely recognise the importance of clear and consistent communications to people at national and local levels. The Scottish Government puts out messaging on accessing the right care at the right time in the right place. That ensures that people understand the options that are available to them and how NHS 24 can support them in accessing the option that is right for them. That might be done through the telephone system but, equally, people can look at the online resources and the self-help guides that I referenced earlier. We work with all the communications leads across our NHS boards to ensure that there is consistency in that messaging; at national level we should reinforce the message that is put out locally, and the local message should relate to what is being said at the national level.

It is clear that people can help to support services through the winter and through other pressured times by accessing the services that are right for them and by using online resources to support their own care. I will ask John Burns whether he wants to add anything to that.

Carol Mochan's point about different pathways was really well made. We need to be mindful that some people will be quite resistant to accessing health and care services in different ways, so we need to work with them and support them by being clear about how they can access different services in different ways.

**Carol Mochan:** You might, in the previous evidence, have heard one of the medics say that, last year, one enormous pressure related to Strep cases. He felt that the system was not easily able to quickly change its messaging for parents. Have you learned lessons from what happened last year so that things might be better if we have a similar situation in the future?

**Caroline Lamb:** Yes—I am sure that we have learned lessons about messaging from that. Clearly, that was a really difficult situation. I do not think that anybody would question a parent's concern about their child in that sort of environment. That was a high-pressure situation, and the system responded really well to it, but there are lessons that can be learned for us all.

**John Burns:** Because of the consistency of messages that has been provided over the past four years following the redesign of urgent care, people right across Scotland are embracing those messages and are behaving and engaging differently. There has been increased use of NHS 24, and in an average week NHS Inform gets 2.5 million views. The number can go up to more than 3 million in the winter. More people are also accessing the pharmacy first service on a weekly basis. Therefore, we have seen change, with people accessing services differently, but we need to continue to provide that consistent message.

**Carol Mochan:** Thank you.

**The Convener:** We will move on to our final topic. I will bring in Sandesh Gulhane first.

**Sandesh Gulhane:** I will ask the same question that I asked the first panel. I and other GPs find it very difficult when a patient, after going to an A and E department at the weekend, turns up and says, "Oh, someone in A and E asked me to come and see you", because I will have no idea why if I have not received a document from the A and E department. Our systems do not communicate with one another efficiently. What are you doing now to ensure that we have consistent good messaging between us, given that we have been talking about this for an awfully long time?

**Caroline Lamb:** First of all, I accept that we are not yet where we want to be in relation to having joined-up systems. That applies not just to the interface between A and E departments and GPs but to many other areas. As we have said, we have put in place data-sharing agreements with all our health and social care partnerships in order to share performance data on how the system is operating. Clearly, we also need to focus—and are focusing—on how we can improve connectivity across all bits of the system, including between primary care and acute care and between acute care and social care. Some progress is being made through the portal approaches, but there is not yet consistency across the country.

We have the opportunity to be much clearer about information governance requirements in the National Care Service (Scotland) Bill, and therefore we will be able to be much clearer about what data we expect to be shared, because knowing what information people are able to see from their own records is also critical. I agree that we are not yet where we want to be, but we have an ongoing programme of work on considering how we can smooth some of the information flows. I do not think that we are exactly where we need to be, but work is ongoing.

11:45

**Sandesh Gulhane:** Okay. There is ongoing work, but it has been going on for a decade plus, and we are not there yet. The interface between all our different areas is dangerous; that includes primary care and specialties.

I ask about this all the time. In other countries, repeat prescriptions can be done automatically for GPs. If we had that here, it would mean that I, as a

GP, would not have to sit and sign a thick stack of prescriptions that I do not really have time to read, but just have to get on with. When will we have repeat prescriptions done in that manner?

**Caroline Lamb:** That is a part of our digital prescribing programme. John Burns can provide an update on where we are with that.

**John Burns:** The latest update that I received was that there has been engagement on what the interface between general practice and pharmacy will be like. Those involved are looking to take forward prototyping, but that will not be in place for this winter.

**Sandesh Gulhane:** When will that happen for repeat prescriptions?

**John Burns:** I would have to get more detail from colleagues who are involved more directly in that work. We can add that information to our correspondence to the committee.

**Emma Harper:** I am interested in digital care. We have Near Me. When I was reading my papers for the committee, I found out about Connect Me, which seems—so that people feel more connected, rather than feeling remote—to have evolved because of use of language that was remote. We have telehealth and telemedicine—all this telestuff—and now we have Connect Me, but none of my nursing colleagues has heard about Connect Me.

What work do you think needs to be done to help people to understand what Connect Me is all about? I understand that technology enabled care is beneficial, especially, as John Burns mentioned, in cases of chronic obstructive pulmonary disease, through chronic respiratory early warning scoring—CREWS—in the community to keep folk out of hospital. I am very familiar with that, but I am interested in how we get info out to people about what digital solutions are out there.

**Caroline Lamb:** I am sure that you are aware that Connect Me is one of the systems that does remote monitoring work for us. It provides a link to use of wearable devices, or whatever, and there is the ability to monitor them centrally. As part of the push for hospital at home, we need to think about how we are able to describe exactly what hospital at home is and what the opportunities are for remote monitoring, because it is an integral part.

I take your point that we need healthcare professionals to be confident about using digital technology and to understand what is available to them. Along with our digital colleagues, we need to think about how to progress that programme of work.

**Emma Harper:** Technology enabled care in Scotland has a Twitter—or X—account, but folk in Dumfries and Galloway dinnae do Twitter, thank goodness; they do Facebook. Should we use different social media platforms to help to raise awareness about the work that the Scottish Government is doing on digital tech solutions, for instance?

**Caroline Lamb:** We have some very good and strong pockets in which our technology enabled care programme has been adopted. The challenge is in how we spread that across Scotland. I suspect that we might want to use social media platforms to do that, but equally, we need to ensure that awareness of those things is part of our core package of improvements in local systems, and that our local systems are taking advantage of all of the opportunities to educate their workforce and to promote improvements across their workforce using whatever method is most appropriate for the locality.

**The Convener:** Thank you very much for your attendance today. The witnesses can leave, and members will continue with our other agenda items.

# Subordinate Legislation

## National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2023 (SSI 2023/181)

11:50

**The Convener:** The next item on our agenda is consideration of a negative instrument—the National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2023. The purpose of the instrument is to increase the prescription charge that is applied to English prescription forms that are presented for dispensing in Scotland. The policy notes state that the uprating will align Scottish charges with English charges, which were increased on 1 April 2023.

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 27 June 2023, and it made no recommendations in relation to the instrument. No motion to annul has been lodged with regard to the instrument. I propose that the committee make no recommendations in relation to the negative instrument. Do members agree?

**Members** *indicated agreement.*

**The Convener:** Our meeting next week will be a session with the Cabinet Secretary for NHS Recovery, Health and Social Care, concerning the programme for government for 2023-24.

11:51

*Meeting continued in private until 12:31.*

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

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

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

The Scottish Parliament
Pàrlamaid na h-Alba