OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 21 November 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
35th Meeting 2023, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Ruth Maguire (Cunninghame South) (SNP)
*Ivan McKee (Glasgow Provan) (SNP)
*Carol Mochan (South Scotland) (Lab)
David Torrance (Kirkcaldy) (SNP)
*Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Greig Chalmers (Scottish Government)
Professor Anna Glasier
Stephen Lea-Ross (Scottish Government)
Siobhan Mackay (Scottish Government)
Dr Pam Nicoll (NHS Education for Scotland)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 21 November 2023

[The Convener opened the meeting at 09:16]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning and welcome to the 35th meeting in 2023 of the Health, Social Care and Sport Committee. I have received no apologies for this meeting.

The first item on our agenda is to decide whether to take items 4, 5 and 6 in private. Do members agree to do so?

Members *indicated agreement.*

Healthcare in Remote and Rural Areas

09:16

The Convener: The second item on our agenda is the first oral evidence session of the committee's inquiry into healthcare in remote and rural areas. We will hear from representatives of the Scottish Government and NHS Education for Scotland. I welcome Stephen Lea-Ross, deputy director of health, workforce planning and development, and Siobhan Mackay, interim deputy director of primary care capability, both at the Scottish Government. Dr Pam Nicoll is associate director of medicine and leads on the national centre for remote and rural health and care at NHS Education for Scotland. We are expecting Professor Emma Watson, the executive medical director of NHS Education for Scotland, to join us. Dr Nicoll is joining us remotely. Thank you and welcome.

We will move straight to questions.

I am keen to hear how the work of the Scottish Rural Medicine Collaborative informed the plan for the new centre and what additional areas the centre will cover.

Siobhan Mackay (Scottish Government): The development of the rural centre is very much the product of lots of discussion about the implementation of the 2018 general practitioner contract. Hearing and responding to the concerns about implementation of the contract in rural areas, a rural working group was set up, chaired by Professor Sir Lewis Ritchie, to explore that and try to find solutions. It covered a range of issues that were informed by lots of engagement across rural communities, within the health and social care workforce and with users of services.

One of the working group's recommendations was the development of the rural centre, which NHS Education Scotland has now been commissioned to take forward. In scoping the centre out, NES has built on the original engagement that took place in Sir Lewis's work and will continue to engage broadly with a range of rural interests, the workforce and users as that work progresses. Sir Lewis Ritchie said previously that he hoped that the centre will be an international example in that space, and that it will pick up many of the issues that the working group's broader report looked at, including recruitment and retention, education and training, research and evaluation, and leadership and good practice. I will hand over to Pam Nicoll at this point and she can give a bit more context from NHS Education for Scotland's perspective as it moves forward.

Dr Pam Nicoll (NHS Education for Scotland): We have worked closely over many years with the Scottish Rural Medicine Collaborative and we are a member of it. We will take forward and build on all the learning and the outputs from its work in our work within the national centre.

Part of the aim of the national centre is to work in a very streamlined manner, bringing under one virtual roof all the work from the Scottish Rural Medicine Collaborative and a variety of excellent programmes of work carried out across Scotland to address health and care in remote and rural and island areas over many years.

As Siobhan Mackay has highlighted, this allows us to work across all four priority areas in a co-ordinated and streamlined manner, but very much building on the work that has come before and particularly on our work within the Scottish Rural Medicine Collaborative.

The Convener: I should mention my entry in the register of members' interests—I am a registered mental health nurse.

When I was reading through the work of the Scottish Rural Medicine Collaborative and its final bulletin to members, I was struck by how medically dominated it was. There was a lot of talk about GPs—Siobhan Mackay referred to GPs—and even the workstreams seemed to be very focused on doctors and on the need for recruitment and retention in that area. How will you ensure that the centre does not focus solely on medical staff and that the scope is widened out to include nurses, allied health professionals and so on?

Siobhan Mackay: I will kick off and then bring Pam Nicoll back in.

Part of the discussion around the 2018 contract was on some of the challenges around the establishment of the multidisciplinary team and full implementation of the contract in relation to that. That was very much in the scope of the discussions around the rural working report and the rural centre. I know that the rural centre will be looking at the broader scope of professions across the health and social care workforce.

Dr Nicoll: We are very much focused on the multidisciplinary workforce. Our chosen way of working is to focus on the rural team in order for it to be as inclusive as possible across community services and primary care services. From an NES perspective, we have been working for the past 16 years on remote and rural and island education, supporting workforce development in that area. We have taken a multidisciplinary approach to that in all cases, to good effect.

We find that there is learning to be gained from specific professional groups and when we achieve something in a specific professional group, we are keen to look at where it is possible to transfer that learning across to other groups.

From the national centre perspective, all the evidence that we have—and all our success in the past, particularly around remote and rural and island education and training—has been around supporting a multidisciplinary approach and we will be taking forward that approach across the national centre work plan.

The Convener: It would be helpful to see some more detail around that work plan because that certainly was not what I was getting from the reading that I did in preparation for the committee meeting.

Emma Harper (South Scotland) (SNP): Good morning, everybody, and good morning to Pam Nicoll online.

I am interested in issues around the impact of the national centre for remote and rural healthcare. I am thinking about actions, the delivery of the strategy and plans. We have had previous papers, including papers from the remote and rural areas resources initiative and the review of the 1912 Dewar commission paper, for example. Professor Jason Leitch has spoken about the Nuka system of care in Alaska, which is about community-owned delivery of healthcare rather than it being done to people. I remind everybody that I am a nurse—I remember Professor Jason Leitch talking to us about rural healthcare in the late 1990s.

I am interested in how NES will ensure that the work of the centre focuses not only on strategy development but on actions, delivery and impact.

Siobhan Mackay: I will come in first agai, then hand over to Pam Nicoll.

Siobhan Mackay: If we are to consider what success looks like, our ambition for the centre is that through its work we see an improvement in the sustainability, capability and capacity of rural and island primary care and that we increase capacity in the multidisciplinary community-based workforce across rural and island communities, so that more people can get the right care at the point of contact. We want improved outcomes for people in such communities.

Dr Nicoll: Thank you for that question. We are very aware of Scotland's strong history of addressing and identifying the health and care challenges of our remote, rural and island communities.

We worked on an extant policy on delivering remote and rural health and care—we led on the education and training work on that. During the decades since, there has been a range of very helpful programmes of work and initiatives, as Emma Harper identified, that highlight the needs

of remote rural and island communities and the challenges of addressing service delivery issues and supporting the workforce in such areas.

In 2008, the Scottish Government supported the establishment of the first permanent team—the NES remote and rural health care education alliance—and for the past 16 years we have been delivering education, training and workforce support. However, we are very keen to also be able to leverage the expertise of partners across Scotland who have expertise in remote and rural research and evaluation, in the development of leadership skills and good practice and also in recruitment and retention.

We do a great deal of work with our international remote and rural partners, and we have a great deal of evidence of programmes of work that have been practically implemented in other countries, as well as across parts of Scotland, that we want to take forward.

The outcome of all that is that our delivery plan is very practically orientated. We are heavily focused on specific programmes of work that are now bringing all those elements together. That means that although we may previously have worked on education and training but not necessarily been able to back that up with appropriate impact evaluation and practical research into whether it works, how it works, where it works and for whom, in order to be able to take that to areas in Scotland, we can now do that. We will be able to leverage expertise across all those areas using practical programmes of work that address the priority needs that the centre has been set up to support.

I thank you for that question, because we are very determined that our work—particularly around recruitment, retention, research and evaluation—will be incredibly practically orientated and that it will be focused on getting the results out and sharing them with our workforce as quickly as possible.

Emma Harper: You mentioned monitoring and evaluating whatever is implemented. We have had a permanent group looking at rural healthcare for 16 years. How are we monitoring and evaluating that?

I will roll that in with my final question. How will the centre work with integration joint boards and local authorities to ensure that the work is delivered directly at the point that it is needed, which is in our remote and rural areas—fae Shetland tae Stranraer, for instance?

Siobhan Mackay: I will come in again, briefly, and then I will hand back over to Pam Nicoll.

There is a commitment to evaluate the centre. The centre is funded with around £3 million until 2026 and evaluation will take place after year two to look at the impact that the centre is having and to consider its future.

Initially, as proof of concept, the centre is focusing on primary care, and NES might want to speak about the broader scope that it would like it to have. We see the centre as a hub of support for health boards and health and social care partnerships. Pam might want to talk about how it is linking in with those.

Although the centre is focusing on primary care, the aim is that the work that it is doing and what it achieves will be a learning opportunity and that it will be replicable in other settings beyond primary care.

09:30

Dr Nicoll: Yes, absolutely. I will follow up on that aspect. We will be heavily reliant on establishing excellent collaboration with our health board, primary care and local authority partners and a range of other agencies across Scotland in order to deliver on that and really achieve an impact.

From a NES perspective, on the first part of your question, it is reasonable to say that, over the past 16 years, we have become world leaders in Scotland in delivering and designing remote, rural and island education and training and supporting our workforce. We have a happy history of requests for visits from other countries that want to understand what we are doing and how we are delivering it. There is still more work to be done.

Over the past 16 years, that work has been measured in NES through our own governance process, reporting to the NES board, for example, and then back to the Scottish Government in our role as delivery partners on behalf of the Scottish Government with regard to that work.

After today's meeting, I would be happy to share the track record that we are building on and bringing into the national centre. We acknowledge that there is more work to do, but we have a great deal of expertise already in Scotland upon which to build and take this work forward. We are very much in partnership with people in our communities, local authority partners and a range of partnership agencies in order to deliver and make an impact.

The Convener: I remind those in the room that you do not need to operate your microphones; broadcasting will do that.

Tess White (North East Scotland) (Con): My questions are to Stephen Lea-Ross and Siobhan Mackay. Earlier this year, I attended a round-table meeting with the Royal College of Nursing, which focused on student finance. There was an

example from one of the students who had got a placement on the Isle of Skye. She had found accommodation but it had to be registered with the council. Due to housing availability in such a remote location and the cost being prohibitive, she had to withdraw from that placement. What is the Scottish Government doing to support student nurses who want to train in rural and remote areas?

Stephen Lea-Ross (Scottish Government): I can pick that up first. The Scottish Government continues to offer all student nurses across all programmes an annual bursary of £10,000 in addition to support with tuition fee costs. There are additional costs. I do not have the figures to hand but, if the committee would like, I can enumerate the additional financial support in relation to additional out-of-pocket expenditure that is related to placement activity across the country.

That combined package of financial support is the most advantageous that is offered anywhere in the United Kingdom, but it is being reviewed in line with the evidence that we are taking as part of the nursing and midwifery task force, which was commissioned on the back of the 2023-24 agenda for change pay offer. That task force is looking expressly at attraction, selection and the package and offer of support that is available to nurses in training as well as to attract graduates to posts across the country; in particular, it is looking at the rural and island infrastructure component that poses an additional burden.

Siobhan Mackay: I have nothing to add to that.

Tess White: Stephen, can the RCN follow that up with you and share its experiences?

Stephen Lea-Ross: Yes, of course. The RCN is part of the task force and a leading voice around that table of partners.

Tess White: Thank you.

My second question is to Dr Pam Nicoll. In the north-east, we are seeing a proliferation of 2C GP practices being run by health and social care partnerships, what with the difficulty of recruiting GPs outside the central belt. Indeed, a recent example of that is what has happened at Braemar. What is the Scottish Government doing to address the GP recruitment crisis in remote and rural areas of Scotland?

Dr Nicoll: I can tell you what the national centre is doing with focus work in that area, and my Scottish Government colleagues can give an overview of all the work that the Government is undertaking to improve the situation.

We have talked a lot about the delivery plan for the national centre as a practical example. Some of our priorities for the first 24 months are focusing on a streamlined approach to keeping the GPs that we have and attracting more of them into practice.

We have already begun two key pieces of work. First, we are working to improve support and training for remote and rural dispensing practices. We know that dispensing causes considerable stress for staff, and we know, too, from evidence that some GPs who are attracted to remote and rural practices have concerns about supporting full dispensing functions. That is an immediate priority for us, and we have already begun work to develop education, training and support packages in that respect.

Secondly, we are working to introduce community training hubs in our practices for the first time in Scotland, and we are keen to support 2C practices in that first of all. I will explain a little bit about why that will be helpful. We have had feedback and evidence on the burden that GPs feel with regard to providing training in their practices and yet we know that, to attract more GPs, we have to expose them to positive experiences both during their training and throughout their career in practice in remote and rural areas if we are to achieve a real improvement in recruitment rates.

For a long time in Scotland, a large amount of our training, particularly for our medical colleagues, has been carried out in acute settings in hospitals, and through the national centre, we are now working hard across the country to develop a package of support, education, training, guidance and protocols that will allow remote and rural practices to become what are termed community training hubs. That will attract more GPs in training to remote and rural practices, and we will also have more doctors in training coming through remote and rural practices as part of their training, without increasing the burden on existing staffing.

We intend to do that across the rural practice multidisciplinary team, so pharmacists, nursing staff and advanced practitioners will be included. That work is already under way, and we have chosen specific practices that are geographically spread across Scotland to be involved in it.

Tess White: How much of a priority is that for you? Is it in the top three of your priority list?

Dr Nicoll: Improving recruitment and retention and supporting our existing staff are our top priorities.

Paul Sweeney (Glasgow) (Lab): In its evidence, NHS Dumfries and Galloway has described vacancies as

"a staggering challenge that is on par with the financial issues."—[*Official Report, Health, Social Care and Sport Committee,* 2 May 2023; c 29.]

Can you provide further detail on the extent of vacancies in rural areas and on what can be done to attract people to such roles?

Stephen Lea-Ross: I am happy to pick up that question. Since 2019, we have seen across Scotland overall an upward trajectory in the number of vacancies in the principal job families of nursing, midwifery, medicine, dentistry and AHP. However, although the number in each family has risen precipitously in that time, we have also in the past 12 months seen a drop in vacancies in nursing, midwifery and AHP roles.

Overall, there has been an upward trend in vacancies in medicine and dentistry in our rural and island board areas such as the Borders, Highland, Orkney and Shetland—although for Shetland, Western Isles and Orkney such fluctuations are nominal—while vacancies in nursing and midwifery and AHPs have been on a downward trajectory for the past 12 months, including both staff in post and advertised vacancies. That picture is likely to reflect recent recruitment efforts. For example, about £18 million-worth of funding has been provided to recruit international nurses, midwives and AHPs, and so far that funding has successfully recruited staff for around 1,250 such posts. It also reflects a shift in the configuration of job families following the Covid pandemic.

As they stand, the trends also reflect the pre-pandemic pattern of there being, comparatively speaking, more of a challenge with recruiting to medical and dental posts in rural and island settings than to nursing and midwifery posts, which is the inverse of the position in our urban areas.

Paul Sweeney: Thank you for outlining those trajectories. I would just highlight the underlying pressures in the domestic workforce, though. I recently joined a round-table meeting with representatives of the Royal College of Nursing Scotland, at which students cited examples of their wanting to do placements in rural areas and on islands but being unable to do so, because of financial constraints on their student bursaries. Could more work be done to support and incentivise rural placements so that the significant financial cost would not be detrimental—or a complete disincentive—to students participating in placements in such locations?

Stephen Lea-Ross: As I have said, the attractiveness of placements in rural and island settings is being actively considered through the work of the nursing and midwifery task force. We are aware of a financial element to that, which has been raised by the RCN and other colleagues.

There is clearly an infrastructure element, too, which we have been considering directly with colleagues on the island boards. For example, we have been exploring the availability of accommodation for both placement activity and peripatetic appointments in such settings, and working with colleagues across Government to release funding to increase accommodation capacity. For example, NHS Shetland's board was recently supported by the Government in purchasing a guest-house facility and repurposing it to house peripatetic and placement students.

In short, we are aware of a direct financial component to the situation as well as a broader infrastructure element, and the two aspects need to be considered in tandem.

Paul Sweeney: What other efforts are you putting into developing housing capacity? Are you just purchasing existing stock, or is there potential to develop more housing around clinical sites?

Stephen Lea-Ross: In our engagement with colleagues across Government who are leading on the rural development plan, we have picked up the question of key worker housing. By that, I mean not just providing housing for placement and peripatetic staff, but increasing housing availability more generally as part of the effort to attract staff to live and work in the communities that they serve, which includes both local or domestic and international recruitment efforts. Off the top of my head—I would have to double-check the figure—I think that the commitment is around £30 million-worth of investment, as part of the Scottish Government's broader housing strategy commitment to invest in new housing to support key workers across the country.

Sandesh Gulhane (Glasgow) (Con): I want to ask a direct question about the 2018 GP contract. Was the Scottish Government told that the GP contract would negatively impact rural and island GP and primary care settings?

Siobhan Mackay: I will come in on that. I cannot comment specifically on what might or might not have been told to the Government at that time. However, I am aware that concerns were raised, and since then, work on the matter has been on-going through Professor Sir Lewis Ritchie's group and discussions with the British Medical Association on moving towards the phase 2 commitment to continuing to take account of the needs of rural communities.

We have talked about the centre, which is very much the product of that discussion—

09:45

Sandesh Gulhane: We have talked about all of those things, but I asked a very direct question. If you do not know the answer to it, perhaps Stephen Lea-Ross does. Was the Government

told back in 2018 that the GP contract would negatively affect rural and island communities?

Stephen Lea-Ross: I am afraid that I am not aware of that.

Sandesh Gulhane: There was certainly a lot of discussion at the time—and at this point I should declare an interest, not just as a practising NHS GP, but as someone who sat on the BMA Scottish general practitioners committee at the time of the contract. I know that rural GPs were making a lot of noise about the contract negatively affecting those areas. How much of a gap was there between the introduction of the 2018 contract and the putting in place of all the things that Siobhan Mackay mentioned?

Siobhan Mackay: My understanding is that the rural working group, which was very much focused on implementing the GP contract in rural and island areas, was established in 2018 and reported in 2020, making a number of recommendations, as you have rightly mentioned. We have already covered the national centre, and many of the recommendations in Professor Sir Lewis Ritchie's report will be picked up there. Other recommendations included ensuring that no GPs in rural communities or elsewhere lose out, so the incentives guarantee—as I think it is called, if I remember correctly off the top of my head—will be continued. I think that that was worth about £23 million, and it has been uplifted. There is a range of other funding initiatives to support rural communities, and work on dispensing practices is actively on-going and will be picked up in guidance and training materials from the centre.

The work to respond to the concerns has been going on since 2018 and is continuing. As we approach phase 2, there is, as I have said, a commitment to continuing to engage on what the rural dimension looks like.

As for the establishment of the MDT, our GP colleagues have made it quite clear that services should be handed over to the NHS boards only when it feels safe to do so. If GPs want to continue to deliver some services, we are by no means opposed to that.

In terms of implementation—

Sandesh Gulhane: I am sorry, but can I pick you up on that? What if there were, say, a vaccine delivery system that lots of GPs in the Highlands would like to take on, but the health board said that they were not allowed to? Are you saying that they would be allowed to deliver that vaccine programme?

Siobhan Mackay: My understanding is that the health board and the GPs can have that conversation, and services should be handed over only when it is felt that it is safe and appropriate to do that. I am happy to pick up the specific issue of vaccines with my GP colleagues and to provide more information on it, if that would be helpful.

Sandesh Gulhane: That would be very helpful. Thank you.

My next question is for Stephen Lea-Ross. Tess White asked about numbers. What are the numbers of physician associates in primary care in the Highlands or in other rural settings?

Stephen Lea-Ross: I am not directly aware of the number of physician associates working in GP settings in the Highlands and Islands, but I can say that, overall, a comparatively low number of physician associates work in NHS Scotland, both in GP settings and in health board settings. The overall number is in the low 200s to 300.

Sandesh Gulhane: But that number is growing.

Stephen Lea-Ross: Yes, but nominally, compared with growth in other disciplines.

Sandesh Gulhane: What is the role of a physician associate in primary care?

Stephen Lea-Ross: As has been set out, the role is to support the delivery of primary care services, and they can undertake broad-based activities relating to the delivery of healthcare—providing, of course, that they are appropriately trained and supervised. We also specified in a direction letter in 2016, I think, how we expect that to be communicated and enumerated to patients receiving services, too.

Sandesh Gulhane: My final question about physician associates is really important. If you look at some material that is coming out, physician associates are talking about being GPs. Undifferentiated patients are being seen by physician associates, who, although they have a degree and two years of training, do not have what a senior nurse, such as an advanced nurse practitioner, who has done many years to be at the point where they are seeing someone, would have.

With the difficulty in recruiting in rural areas, are we in danger of seeing a two-tier health service, where compared to people in better-off areas, people who live in rural or deprived areas are more likely to see a physician associate than to see a general practitioner?

Stephen Lea-Ross: I do not believe that that would be the case in the context of the trajectory that we are on within the NHS in Scotland and the commitments that have been made by the Scottish Government. In connection with general practice, there is an outline commitment to increase the number of GPs by 800 by 2027. We have seen record increases in the number of undergraduate medical places, alongside record increases in the

number of GP specialty training places, with a commitment to deliver a further 100 places over the next three years. We have also expanded our Scottish graduate entry medicine programme—ScotGEM.

We train comparatively small numbers of physician associates domestically. There is a small programme within the University of Aberdeen of about 40 per annum. As I said a moment ago, we have broadly 200 to 300 physician associates working across the service. We have committed to looking at the role of physician associates, along with that of other medical associate professionals, over the next couple of years by independently evaluating that in line with recommendations that came from a report that we commissioned from NES on the role that medical associate professionals can play within and across our health service. We have committed, pending that evaluation, to only modest increases in training numbers across the suite of professionals.

The Convener: Emma Harper has a supplementary question before we move on.

Emma Harper: I will pick up on ScotGEM. I recently met the chief executive officer of NHS Dumfries and Galloway, Jeff Ace, who said that the retention of ScotGEM graduates in Dumfries and Galloway was excellent.

I have an article here that says that 55 people have completed the first four-year graduate entry to medicine programme, which is unique to Scotland. My colleagues in Ireland, as part of the British-Irish Parliamentary Assembly, are looking to Scotland to learn about ScotGEM so that they can maybe implement it elsewhere.

I am interested in your findings regarding ScotGEM. Is it successful? Has it proved to be supporting rural recruitment for general practice across either side of the central belt?

Stephen Lea-Ross: In one sense, it is a little bit early to do the final analysis because we have had only the first group of graduates. In relation to those 55 graduates, we can see that there has been successful retention on to foundation training programmes. We anticipate a further 40-odd graduates this year. We have expanded the programme in line with our broad expansion of undergraduate medical places. The intake for ScotGEM for this year was 70.

We are seeing that it is delivering, certainly in relation to the vast majority of the clinical and pre-clinical training activity as part of the degree programme in Highland, Dumfries and Galloway and also on the east coast, with indications from the students that their intention to pursue a career within medicine in Scotland and to remain in the locality in which they were trained is at a higher rate than that of other groups of undergraduates.

Emma Harper: That is fine. That was a good enough answer—thank you.

Ruth Maguire (Cunninghame South) (SNP): I will ask about palliative care in rural areas. In the chamber last week, we debated inequality at end of life, so it will be fresh in members' minds. The most recent evidence to the committee from Marie Curie, which was on the national care service, highlighted inequity in accessing palliative care in rural areas. What role could the national centre have in making sure that our citizens in rural and remote communities know what palliative care is and how to access it?

Siobhan Mackay: I will come in before handing over to Pam Nicoll for some thoughts on palliative care. As we have said, the national centre is focused on the primary care setting. I cannot speak in a lot of detail about palliative care, but the primary care team who support the person who is receiving palliative care will have a role. I am sure that thinking about how the primary care team connects with specialist services, the third sector and beyond to provide support for people who are in remote, rural and island settings will be in NES's sights.

Dr Nicoll: One of the national centre's priorities is the need to support our staff to be as skilled as possible to deliver as much care as possible as close to home as they can for the wide range of communities across our remote, rural and island areas. From NES's perspective, palliative care, the provision of high quality mental health support and paediatric care continue to be very high priorities and areas where there is a significant and on-going need to continually update staff knowledge and skills. The national centre will have the ability to understand varying needs across different remote, rural and island communities, working with citizens through stakeholder networks to understand where the gaps exist and how we can use our expertise to address them.

Within NES, we have experts on palliative care education and training who already work across the multidisciplinary team. Our job is to understand where the gaps exist across the remote, rural and island workforce and to provide support to address the gaps in skills, capability and capacity. In that way, we will work to increase the access to good quality, skilled support for the citizens who live within those communities, now and into the future.

Ruth Maguire: I am finding the session very focused on staff, which, in many ways, is understandable. However, I am particularly interested in patients. Pam Nicoll spoke about the gaps in services. Could you give some specific examples of gaps that you have identified and how

those will be plugged? We would all be keen to see that the folk in rural communities whom we represent are afforded the same choices at the end of their lives, whether that is to end their life in a hospice or to be at home. Those two things will have unique challenges, depending on where in Scotland someone is based.

Dr Nicoll: We work closely with remote and rural communities from an education and training perspective to understand changing needs—that has been our history. There is no one-size-fits-all approach; each community has a different range of needs and each rural team will have a different skillset. We have developed an understanding of how to identify specific gaps where we can marry up what is already being provided within communities. For example, we will identify excellent hospice work across remote and rural areas and will work with those teams to look at delivering educational support or supervisory support for staff so that they can feel confident and competent to deliver excellent palliative care within their local areas.

If it is appropriate to step away from palliative care for a moment, I will provide other some examples of gaps that we have identified. Scotland has not had a specific training programme to train our growing group of practitioners in rural areas who are working at advanced practice level. We expect that workforce to continue to grow and to work alongside the other members of the rural team. We have now developed the first rural advanced practice programme in the UK, which means that health boards and primary care practices no longer have to take on that work individually.

10:00

We are currently funding the first cohort of those practitioners to go through the programme. There are priority areas in which rural practitioners need to have increased skills, and an increased range of skills, to deliver that type of care in their local area—

Ruth Maguire: Sorry—I will jump in there. It is difficult when you are appearing remotely—if you were here, I would be trying to catch your eye rather than interrupt you.

Can you speak to what that would look like for a patient? What difference do the improvements that you have made mean for patients?

Dr Nicoll: Certainly. We will measure what the impact of changes and improvements on patients is by, for example, looking at a specific remote and rural or island setting where the healthcare practitioner will have an increased range of skills that are, increasingly, matched to the local community health needs as we go forward.

One of the ways in which the national centre will be different is that it will be using and gathering more data, gaining more understanding and engaging more closely with local remote and rural and island communities across Scotland, in order that we can fulfil that commitment.

As we talked about earlier, we will measure the impact of that in a practical way, by asking whether the approach is making a difference on a regular basis and ensuring that we are delivering measurable change that has an impact on patients. It will be making an impact by supporting service delivery, which we will do through supporting the workforce capability and capacity to deliver an improved service. In addition, there will be a difference in that we will be measuring the impact in a very practical and on-going way.

Ruth Maguire: I will press you a little on that one final time. What would that measurable difference be? Would it mean that somebody does not have to travel to get treatment, or that they will get treatment more quickly? What will it mean for a patient?

Dr Nicoll: Where it is possible to have increased service delivery, or if that is the improvement that is required, and there are staff in the local area whom we can support to deliver that care, that would be one example of what improvement would look like.

Sandesh Gulhane: I will ask about alcohol services. When the committee put out a call for views, some of the biggest respondents talked about alcohol services. Obviously, you will be aware—as everyone is—of the large number of alcohol deaths in Scotland. What increases or improvements have there been in alcohol services in rural areas?

Siobhan Mackay: I do not have a lot of detail on that, but I can say that the Scottish Government continues to be committed to addressing the high levels of alcohol harm in Scotland. It is working collaboratively with alcohol and drug partnerships across Scotland in order to understand and to help to resolve issues, and to support partnerships in identifying ways to improve waiting times.

There has been increased investment from the national mission on tackling drug-related deaths, which is being used by ADPs across Scotland to support people who are dealing with alcohol and drug abuse. In 2022-23, £106.8 million was made available to support local and national initiatives that are overseen by ADPs, thereby ensuring that local services—

Sandesh Gulhane: I am sorry. Forgive me, but I am asking specifically about rural areas. What is there in rural areas to help people with alcohol addiction issues specifically?

Siobhan Mackay: We do not have material specifically on rural areas, but what I have described will be supporting rural activity. We could certainly follow up on that with the committee.

Sandesh Gulhane: Absolutely. It would be great if you could let us know what is available and what increases and improvements have been made in respect of alcohol services. If you could do that for each year, including information on alcohol brief interventions, beds that are potentially available for people who want to detox and waiting times, that would be fantastic. Thank you.

Carol Mochan (South Scotland) (Lab): I am interested in how we might change to a more preventative model in the NHS and how we support that essential work to help people in our communities and the population generally. On reform in that direction, are the challenges in rural areas different? We talk a lot about the demographic changes in the rural population and the rural workforce. Are you looking at how we can ensure that that reform happens in remote and rural areas?

Stephen Lea-Ross: I am happy to make a start on that question. I will answer it in reverse order. The demographic challenge is more pronounced in our rural and island communities because of the twin effects of ageing and depopulation in those communities. In the context of the broader community-based prevention agenda, that situation exacerbates the total burden of long-term chronic illness that we anticipate managing with regard to demand for healthcare.

We are considering specific things in the context of bringing forward the remote and rural workforce recruitment strategy, under the auspices of our national workforce strategy, which considers the skills mix that is needed for rural and island working, particularly where there are lone practitioners and smaller multidisciplinary teams of community-based practitioners.

However, with regard to our public health and prevention agenda, it is also clear that there will have to be a growing role in matching the availability of workforce and service provision with the national and international demographic challenge that we face as a result of having an ageing population across the west. That is a key focus of the care and wellbeing portfolio and of the proposal to bring forward a further suite of activity to consult on how to sequence preventative action in relation to messaging, public knowledge and people being in control of understanding their own health needs and dealing with the fact that, given the burden-of-disease projections, we will be managing more chronic ill health in the community.

That speaks to colleagues' earlier questions about the types of skills in areas—rural and island settings—where we would focus on building up the skills mix of staff. Those would include skills in palliative care, respiratory conditions, long-term conditions that are associated with obesity, diabetes management and things of that nature.

Carol Mochan: Will the development of the national centre help with looking at that for remote and island communities?

Stephen Lea-Ross: There is absolutely scope for the centre, once it has been embedded, to reach out to pick up the broader long-term cross-disciplinary focus on preventative healthcare that will be needed. As things stand, it has four workstreams in the activity that it has been commissioned to deliver, some of which is about increasing recruitment and retention capacity and diversifying the skills mix. Therefore, there is a natural synergy and there is a longer-term decision for ministers to make about how the role of the centre could be broadened.

Carol Mochan: Siobhan—do you have anything to add?

Siobhan Mackay: I probably do not have much to add. The chief medical officer published the "Value Based Health and Care: Action Plan" last month to support the delivery of realistic medicine. In that action plan, he talks about the fact that every healthcare contact is an opportunity for preventative activity. I go back to Carol Mochan's point about the role of the national centre in that. Pam Nicoll might have some reflections on working in a rural and islands context and the importance of growing MDTs—the growing local primary and community care workforce—and ensuring that they have the skills, confidence and tools to drive forward the approach in which every contact is an opportunity for preventative activity.

Carol Mochan: Pam, is that something that you feel the centre will be able to help with?

Dr Nicoll: Yes. That is a really excellent question. We are focused not just on addressing our existing priorities but on supporting, training and shaping our practitioners to be fit for meeting our population's future needs, and on understanding the demographics in a range of rural and island settings, because, of course, they are all quite different.

However, the approach is already having a significant influence on how we are designing our education programmes across medicine, as well as our healthcare training programmes and our recruitment and retention work. Perhaps I can give you a little example of what I mean by that. We have strong evidence from the World Health Organization and from other rural geographies that the more we recruit from remote rural and island

settings across Scotland, the greater the retention rate of staff will be. In other words, where staff come from a remote, rural or island area and have access to training and good-quality support, retention rates go up accordingly. That is work that we still have to invest in and evaluate across Scotland.

There are untapped resources in that respect. We know that we are facing a decline in population in many of our remote and rural areas, but we still have work to do to increase access and ensure that we recruit as many people as possible into healthcare professions, so that we have the capacity to deliver for the needs of remote and rural communities. We are working with our academic institutions and our training establishments to try to develop modern and accessible routes to becoming a healthcare practitioner of the future, and we are also seeking to influence the curriculum to ensure an emphasis on preventative care, for example.

It has recently been said that 50 per cent of school leavers in the Western Isles leave the islands and do not come back—or if they come back, they do so much later in life. There are, therefore, related areas that include education and training, increasing access to qualifying routes and a positive recruitment strategy in which we welcome all people to come and work in Scotland.

In particular, we want to increase the number of people who have been brought up in remote and rural areas who are attracted back and retained in health and care careers. As a result, there is a tie-in with what we actually train people to do and whom we attract as our practitioners of the future, so we will begin to have an impact with regard to preventative care and providing the types of healthcare and social care that meet the population's needs now and into the future.

Carol Mochan: Thank you.

The Convener: I call Gillian Mackay.

Gillian Mackay (Central Scotland) (Green): Thanks, convener, and good morning, panel.

Given the changing demographics that we are seeing, how can we continue to move more services towards the community—not just into primary care but into some of our smaller hospitals in remote and rural locations? They are often much closer to communities than, for example, Raigmore is to Sutherland.

Stephen Lea-Ross: I am happy to pick up that question.

From a workforce perspective—which is, I think, the perspective that I speak predominantly from—I would say that the issue with delivering more care in the community is in how we create the enabling conditions that will allow it to happen. Pam Nicoll and other colleagues have talked extensively about skills and capacity. That is partly about the professional skills and competences that are involved in lone working, and some of it is about professional decision making. Alongside that, though, we would highlight how we have improved our service terms and conditions to promote flexibility in the service offering and, as a result, to allow staff to be better dispersed in community settings.

I will highlight another two enabling conditions. One is about how we create, or invest progressively in, the technology and infrastructure that will allow staff to work in a more dispersed way and to be connected. That would involve staff getting support for collective clinical decision making and being able to use the tools that will—as we know from looking at innovations in medical and other clinical services delivery around the world—allow them to give supported diagnoses for conditions through advances in artificial intelligence and other technological innovations.

10:15

The second condition is about how we create the leadership capacity to allow more dispersed network management of staff. There is a service design and patient safety element to that—we have to design services that are delivered in a clinically safe way. Some aspects of specialist and acute care will still require a certain throughput of patients in a given service within a given locale in order for that care to be safe, effective and efficient. That will also continue to be the case for some advance care planned treatment.

As was talked about briefly earlier, we will have a significant focus on creating the enabling conditions that I have just laid out, along with a focus on capacity and skills.

Gillian Mackay: That is great. Pathways are sometimes opaque, to say the least, even when you live in the central belt and go to a major hospital for out-patient treatment. When there are extra complexities of distance, as there are with some of the smaller hospitals, things are even more challenging to navigate.

What work is going on to ensure that the populations that we are talking about have transparent pathways that suit their needs, and to ensure that ageing populations know where, when and how far they have to go for their treatment?

Stephen Lea-Ross: That is, and will continue to be, an on-going challenge as services evolve. Obviously we have to commit in the broadest sense—as the committee would rightly expect—to continuing to signpost access to services, and to continuing to evolve our digital infrastructure and our expectation that health boards and

partnerships, even down to practices, communicate directly with patients regarding access to and delivery of services. As I said, we will have to continue to pay attention to that.

Gillian Mackay: Finally, we know that feedback from patients is essential to on-going service delivery and evolution, but in some communities the doctors and nurses on whom people are giving feedback are their neighbours, and are much more closely related to the community than they might be in more populous areas. Is there active work being done on seeking views from people, so that their feedback on changes can be taken into account? People might be apprehensive because of that close relationship.

Stephen Lea-Ross: Yes. We recognise that, and there are objective mechanisms for seeking feedback, including getting feedback about people's experience of receiving treatment through anonymous fora such as the Care Opinion website and so on.

In addition, in the context of our on-going work to develop the rural recruitment and retention strategy under the national workforce strategy, we have, as well as doing the standard literature review work, visited NHS Western Isles alongside the WHO, and have done some engagement work with staff and service users.

We will continue to undertake outreach work as well, through on-going mechanisms in relation to the nursing and midwifery task force, and by engaging with service users via our tripartite working structures in the NHS.

We also take cognisance of the fact that a number of individual service users have written in response to the committee's inquiry, and we will pick up on those submissions in the next stage of development of the strategy.

Ivan McKee (Glasgow Provan) (SNP): Good morning, panel.

When we talk about remote and rural healthcare, we often look at it through the same lens as we look at healthcare elsewhere. We consider that, for various reasons, healthcare in rural areas is not as good as we would like it to be in comparison with the rest of the country, and we look at how we can improve its standing.

That is hugely important, but I want to flip that around and look at the subject through another lens—in relation to digitisation, remote healthcare, telehealth and so on. There are clearly opportunities for us not only to get ahead of the curve in how we deploy those technologies at scale in rural communities and drive up health outcomes as a consequence, but to position Scotland as a leading global player in those technologies. I know that we have done a lot of that already, and that there are great examples of it in the Highlands and Islands and elsewhere. To what extent do you see the national centre focusing on such opportunities, as it does on the many existing challenges that we have discussed?

Siobhan Mackay: In a broader sense, we have the digital health and care strategy. However, to home in on the work of the centre, I note that the idea of using digital technology to support delivery of primary care services was a feature of the report of Professor Sir Lewis Ritchie's rural general practice working group back in 2020. According to the report's four pillars, digital will be a theme of the centre's work—in respect of how it connects with the healthcare and social care workforce across rural and island areas and with service users to seek their views on training, support and other features, which will be done very much with international examples in mind.

Pam—do you want to elaborate on that?

Dr Nicoll: Thank you, Siobhan.

I agree that it is integral to our work that we be innovative with our community members through the work of the centre, in considering ways in which we can harness our existing digital technology skills to improve access to services and the quality of those services. We already have a track record of pioneering increases in our staff and workforce in remote and rural areas, and in raising their confidence and competence in using technology to conduct their own learning at a distance. Our training programmes increasingly include digital confidence and competence among the range of skills that our rural practitioners have now, and will have in the future. That is therefore very much part of the work of the centre now and into the future.

We are keen to highlight, through our work, the fact that remote, rural and island areas have often been leaders in showing others how to use technology. We want to continue that pattern by using all available technologies, artificial intelligence and low-tech and high-tech solutions to good effect, in order to achieve improved impact in how we deliver services and how patients experience that delivery.

Ivan McKee: Have you specific examples of technology and digitisation having been deployed in rural areas in advance of that happening elsewhere in the country, or are there plans in which that is in train?

Dr Nicoll: Again, NES's experience on that has been in education and training and using technology. We were early adopters of technology. More than 10 years ago, we set up our at-distance healthcare education networks, which have now been running for about 10 to 12 years using available technologies to deliver education in

priority areas of need for a wide range of multidisciplinary staff.

In response to need, we also developed a technology-enhanced learning programme for our learning and development staff in health boards in remote and rural areas. Again, that was first delivered for those staff and is now a rolling programme that they implement themselves, in which they design, for their own staff, high-quality education and training that make excellent use of available technologies and emerging ones.

Ivan McKee: Does anyone have further comments on that?

Stephen Lea-Ross: I add that we see further opportunity in rural and island communities for using the two digital technologies that are already in use.

The committee will be familiar with NHS Near Me in relation to video consultation, and Connect Me, which focuses on wellbeing and allows two-way communication with service users, in that they feed in information about their wellbeing and how it is going, outwith a consultation via text message or app. It also allows them access to a library of services. There is an aspiration to target, through Connect Me, 80,000 folks in relation to supporting a variety of blood conditions, including hypertension, by 2025. There is a focus on rural and island communities in the roll-out of those two programmes.

Tess White: I have a question for Siobhan Mackay. The number of GP practices in rural areas has declined by 7 per cent in the past 10 years—it has gone from 188 to 175. What is the Scottish Government doing to reverse that decline?

Siobhan Mackay: We have the nationwide commitment to increase the number of GPs in Scotland by 800 by 2027. Stephen Lea-Ross has already mentioned that we are making good progress on that at the national level, with record numbers at the moment.

The number of GPs working in rural practices—

Tess White: I am sorry, but my question was about GP practices, not GPs. If you do not have the figure let us know, then answer the question. It is a massive concern that the number of GP practices is declining. Is that decline going to be reversed? If it is, what is the Scottish Government doing?

Siobhan Mackay: We will get back to you specifically on the number of GP practices.

The Convener: That would be very helpful for the committee.

I have a final question, which is specifically for Pam Nicoll. We have heard a lot this morning about the workforce, staff retention and so on, but I have not heard where the patient's voice is in respect of development of the new national centre, or how patients' voices will be heard in following iterations of the centre and their development.

Dr Nicoll: We have talked a lot about improving services through our support for the workforce, which is a large part of the work of the centre. The other very significant part of the centre's work is what we term our "community accountability", which is about patients and citizens. We are establishing stakeholder networks that will take different shapes and forms. The intention is that, rather than having sporadic consultations of citizens and patients, we will establish on-going dialogue, particularly under the four areas that the centre has been set up to support. We will establish networks that will aim to be inclusive and have appropriate representation around the table from a range of communities—north, south, east, and west. They will include patient groups and wider groups of citizens.

In relation to the model of delivery that we are taking forward with the national centre, we are very much adopting the terms "socially accountable" and "community accountable". That, by merit, requires us to demonstrate how we are maintaining dialogue, how we are influenced by and how we are guided by the needs of communities and patients, and the impact that we are having within communities and with patients. That will be a very important part of the centre's work.

In addition to having a strategic programme board, we will establish early next year a range of stakeholder networks—as we have called them at the moment—that will be completely focused on being inclusive of patient representative groups and community members, as well as other stakeholders.

The Convener: That answers part of my question, in relation to what will happen going forward, but where has the patient's voice been in the development of the proposals and the work programme for the centre?

Dr Nicoll: We have taken our lead from the work that the Scottish Government has described, which was done in preparation for addressing the need to develop the centre in the first place. It has been a long time in the planning. Throughout that planning process, we have considered all the information that we have had from a variety of sources and a variety of reports, as well as having considered the matter from an NES perspective. Our on-going engagement within communities and remote and rural island communities up and down Scotland over the past 16 years or so has all been taken into account in shaping the delivery plan that we have for phase 1 of the national centre.

The Convener: I am sorry—I am maybe not being clear enough in what I am asking. Has there been direct consultation of patient groups and patient representatives in remote and rural settings during development of the work plan for the centre and its priorities? I hear what you are saying about how that will happen going forward, but has there been engagement so far?

Dr Nicoll: We have not had a recent series of specific engagement with patient groups in relation to the national centre, but it is in our plan to continue that work. We had established a programme of work for that last year, but we had to put it on hold temporarily while we were waiting to understand whether funding would be established in 2023 for the national centre. We understand that it is a priority, and we will address that early next year within the phase 1 delivery plan targets and objectives.

The Convener: Okay. Thank you.

I thank the witnesses for their attendance at committee this morning. We will briefly suspend.

10:30

Meeting suspended.

10:41

On resuming—

Women's Health Champion

The Convener: Our third agenda item is an evidence session with the independent women's health champion to receive an update on her work since being appointed, and an update on the implementation of the Scottish Government's women's health plan.

I welcome to the meeting Professor Anna Glasier, women's health champion, and Greig Chalmers and Felicity Sung, who are both from the Scottish Government.

We will move straight to questions, and the first ones are from Sandesh Gulhane.

Sandesh Gulhane: I declare my interest as a practising NHS GP.

Professor Glasier, it is great to see you. Women's health is something that we need to talk about more. We need to ensure that more than 50 per cent of our population has equality. With that in mind, why is it that we do not seem to have women's health and equality running through our NHS in the way that we would hope it should?

Professor Anna Glasier: Good morning, everyone. That issue is possibly historical, in that over the years, the NHS has classically been run by men, and quite a lot of the conditions, as we acknowledge in "Women's Health Plan: A plan for 2021-2024", affect women only. Often those are conditions that people find it quite difficult to talk about; even doctors sometimes find it quite difficult to talk about them. Other conditions affect both men and women, but women are often less well managed than men are, clinically.

As members know, women are less likely to be diagnosed as having had a heart attack, and even when they have been diagnosed with a heart attack they are less likely to be on secondary prevention than men are. We have to ask ourselves why that is, and I think that the reason is partly historical, because in the 1950s it was true that men had heart attacks—they smoked, they did manual labour—and people have not moved on from that.

There are a lot of very complex reasons for it, but we are trying our best to change the culture through the women's health plan and encourage people to think differently about women's health, and we are having some success. Everybody whom I have spoken to—and I have spoken to a lot of people in the nine months that I have been in post—is extremely enthusiastic about the plan and is committed to trying to improve the health of women and girls in Scotland.

Sandesh Gulhane: From "Women's Health Plan", it seems that there are very large poverty-related disparities in breast and cervical screening rates. Why do you think that is, and what work is being done or can be done to ensure that we even that up?

Professor Glasier: You are right: there are big differences related to deprivation. Again, the reasons for that are quite complex. We know that women who live in deprived areas find it more difficult to negotiate the NHS than people who live in non-deprived areas. I presume that men in such areas do, as well, but we are talking about a women's health plan.

I am sure that members are familiar with the deep-end practices, which are the 100 practices that serve the most deprived communities in Scotland. We have talked to some of the GPs in those practices and they tell us that women have confidence in their GP but are much less confident in going elsewhere. It is not just a matter of the practicalities of travelling somewhere for breast screening, for example; it is an issue of trust.

10:45

We have been looking at a project that we hope will serve as a pilot for deep-end practices. Instead of asking women to go somewhere for women's healthcare, we will take women's healthcare to the practice. The pilot study that we are considering will allocate to a handful of deep-end practices a women's health specialist for one session a week to work alongside the GPs and practice nurses to improve their skills in providing women's healthcare and to encourage them to take a more holistic view of it. We want to see whether that will serve as a model for improving the quality of women's healthcare in all the deep-end practices.

As you might know, people are looking at self-testing for cervical screening. My understanding is that a validated screening test has not yet gone through the regulatory authorities, but that should happen fairly soon, and it might improve the uptake of cervical screening.

Sandesh Gulhane: I just want to take this opportunity to say how important it is for people to take up their screening offers. It really does save lives and makes a big difference.

In the past few years, maternity services in Caithness and Wishaw have been downgraded, while Dr Gray's in Elgin is still waiting for its consultant-led maternity services to be restored. Are you concerned about the management of maternity services in Scotland? Do you think that they would not have been downgraded and had those problems if it was a men-only issue?

Professor Glasier: I do not know. If I were a rabid feminist, I would jump on that immediately and say, "Yes, of course. If it was all about men, they would be treated much better" but that is an oversimplification. The reality is that there will always be problems with providing the same level of service in remote and rural areas as exists in a big city such as Edinburgh or Glasgow. I do not think that it is a sexist issue, although I might say that in my worst moments.

I have forgotten the first part of your question.

Sandesh Gulhane: Are you concerned about—

Professor Glasier: Am I concerned about the management of maternity services? Yes. The maternity plan is not part of the women's health plan, but the women's health plan does not exist in isolation. A lot of people are working on the maternity plan whereas I am concentrating more on the gynaecology side of things. I keep up to date with what is going on with the other plans and policy teams in the Scottish Government, but I am not concerned with them every day, and I do not think that I could speak about that in a helpful manner.

Ivan McKee: Good morning, and thank you for coming in this morning. I have a few questions about the plan. I think that it is true to say that you came into post a period of time after "Women's Health Plan" was pulled together and launched. To get a sense of whether the plan covers the areas that you think it should and whether its areas of focus are correct, you helpfully unpicked the fact that some conditions are female only, others are shared, and there are some issues that affect the latter category. Do you think that balance is correct?

It was interesting to read in the plan some of the stuff about how women want to play an active role, share decision making and have access to information. That also applies to men. Could any learning from the plan be applied more widely?

I have some more points to make but perhaps you could pick up on those first.

Professor Glasier: I am sure that you are right. It is a women's health plan, but men need health care as well. Often, men are more reluctant to see their GP, which, to answer the earlier question, is another reason why there may be differences from women's health. Women see their GP with women's health issues and during pregnancy and they take their children to the GP. Perhaps when a GP sees a man, they think, "Oh, this guy hasn't been to see me for 10 years, so there must be something seriously wrong." In contrast, when they see a woman, they may have seen her three times that year about something else. I am not saying that that makes people dismissive, but I think that there is a tendency to think that if a man

goes to a GP, the problem must be serious, because they do not go to their GP that often.

There are many things that we could learn from the women's health plan that are important for men. One of the big areas of work is to improve women's knowledge of the various women's health issues. I encourage MSPs, whenever possible when talking to your constituents about health, to encourage them to use NHS Inform. The women's health team has done a huge amount of work on that platform and it is a great resource for reliable and accurate information, which, I hope, allows women and, where it is relevant to them, men to take charge of their own health and to be better informed about everything. I hope that that serves as a model for when we no longer need a women's health plan, but a health plan.

Ivan McKee: On the core question about whether the women's health plan focuses on the right areas, are you comfortable that it does that?

Professor Glasier: It does. It is an ambitious plan with 66 actions. It focuses more on reproductive health, rather than maternity, because there is a maternity health plan. There is also a mental health and wellbeing strategy. There are lots of things that overlap, but the women's health plan focuses on the things that do not appear in other bits of policy. I think that it focuses on the right things and that we will learn from this plan when the next iteration of it is done, so that it becomes even better.

Ivan McKee: Your observation that because women go to the GP more often, they are less likely to be believed is interesting. If anything, you would have thought that more engagement with the health service would have led to better, rather than worse, outcomes.

Professor Glasier: I could ask you when you last went to your GP. You probably do not go very often.

Ivan McKee: You are absolutely correct. My wife tells me that frequently.

Professor Glasier: When the GP sees you, they will take you very seriously.

Ivan McKee: It is an interesting observation that more engagement leads to poorer medical outcomes.

The plan has a big focus on inequality, which is great. It is interesting that women's health outcomes are significantly better than men's for many headline issues, such as alcohol and drugs, Covid and even heart conditions. I think that I am right in saying that men's death rates are still significantly worse than women's. How do you approach those differences, in terms what can be measured?

Typically, when we look at an inequality issue, we would say that one group is performing worse than others and the objective would be to close the gap. In this situation, there are many measures, such as life expectancy, on which women are performing significantly better than men. How would you measure success in closing that inequality gap?

Professor Glasier: You are right about life expectancy being better for women than for men. However, women live with a lot of unhealthy years of life, which is where there are big differences when you compare deprived areas with those that are more affluent. On your question about how we measure it, do you mean how we measure the success of the plan?

Ivan McKee: We have the plan and we have your role. How would you look back in a number of years and say, "Yes, we've been successful"? How would you measure success?

Professor Glasier: We need to do better at evaluating the initiatives that we have set up. For example, in our proposal for working with the deep-end practices in deprived communities, we are planning to include quite a sophisticated evaluation. We want to look at whether, if we improve women's healthcare in those general practices, women are referred less often to specialists.

Fifty-one per cent of Scotland's population are women and all of them, unless they die prematurely, will go through the menopause. I think that all general practices should have somebody who is good at dealing with menopause and prescribing standard hormone replacement therapy. If that is done better, through the various initiatives that we are setting up, we should see fewer people being referred to specialist services for menopause. That is one example.

We are working with NHS Education Scotland to prepare a package for primary care, GPs and practice nurses to improve their knowledge of menopause and menstrual health. We will need to evaluate that and see whether women feel that they are better informed and feel happier with their consultation with the GP. Eventually, as a very long-term measure, we would need to look at whether the statistics change; we would need quite a sophisticated measurement for that.

Ivan McKee: Is the plan clear enough on what those measurable deliverables are, or is there still work to be done on that?

Professor Glasier: No, there is still work to be done. With the next iteration of the plan, we should do better.

The Convener: I will pick up on one of the issues that Ivan McKee raised with regard to what

is or is not in the priorities for the plan. One issue that seems glaringly obvious to me is incontinence. We know that that it is very common in women post childbirth and in later life. We have seen a proliferation of adverts and products in the supermarket that enable women to manage urinary incontinence. Should that be in the plan? Are you considering putting it in? The condition is very treatable, and education and information about pelvic floor exercises would help to alleviate it.

Professor Glasier: Yes. There is a relatively new section on NHS Inform on urinary incontinence, which the women's health team has put in—it contains information about pelvic floor exercises and so on. The topic is not mentioned in detail specifically in the plan, but it often comes into discussions about the menopause, and the menopause features in the plan in a big way.

I was not involved in writing the current iteration of the plan, and we will have discussions with a lot of stakeholders to decide what goes into the next women's health plan. I agree that we should probably have more on incontinence.

Ruth Maguire: Good morning. I would like to ask about progress towards the priority areas of menopause, endometriosis and polycystic ovary syndrome and heart health. Perhaps you can start with menopause.

Professor Glasier: One of the aims of the women's health plan was to have a menopause expert in every health board area, and we now have one in every board area, with a buddy system for the island health boards. We have a national clinical network of menopause specialists who meet quarterly. I must say that it is a very impressive group. When I first started, it was a bit of a talking shop, with people generally saying, "Well, we experience this," and "We experience that."

There is now a more formal agenda. For example, we can say that we need a national pathway on testosterone replacement for women who complain of loss of libido at the time of the menopause, and consider whether, working together as a group, we can bring that about. I think that we are making progress.

Ruth Maguire: I am an MSP for a constituency in Ayrshire. What difference does the menopause expert in NHS Ayrshire and Arran make to the women whom I represent who are going through the menopause? What has the expert done for them?

Professor Glasier: If the menopause expert is used appropriately, they can help women who do not respond to standard treatment for menopause.

If someone went along to their GP with flushes and sweats and said that they would like a trial of HRT, I think that the GP would be able to manage that. However, if that does not alleviate their menopause symptoms, or if they have horrible side effects or they are not eligible for HRT because they have contraindications, they should be referred to the menopause expert—

Ruth Maguire: So the menopause expert is a clinical individual to deal with complex cases.

Professor Glasier: Yes.

Ruth Maguire: What about the standard provision of menopause support for women?

11:00

Professor Glasier: As I said, we are working with NHS Education for Scotland to provide a primary care module for GPs and practice nurses to better inform them about the menopause. Women themselves are now better informed about it—in particular, if they refer to resources such as the NHS Inform pages, which provide them with a lot of information. Health and Social Care Alliance Scotland has also done a lot of work to prepare webinars for women.

"Trendy" is not the right word to describe the subject of menopause, but everyone is now much more aware of it. More women are going to their GPs and asking, "Could this be the menopause?", so GPs are feeling overwhelmed.

Ruth Maguire: May I share some reflections from my constituents?

Professor Glasier: Yes.

Ruth Maguire: Some inequalities and challenges are not so much about individual women's knowledge of what is happening, but about access to support and, in particular, to HRT. In answer to Sandesh Gulhane's question about inequality, you said that the issue is not all about process.

Forgive me—I hate it when politicians do this, but I will give an example from my own experience. Last year, I had to make 25 phone calls before I got in to see my GP, then get a repeat prescription and go to every single pharmacy not only in the town where I live but in my area.

Professor Glasier: Was that because of the shortage?

Ruth Maguire: I am lucky that I can do all that because I manage my own diary. However, I can imagine how things are for someone who has a job where they are working from nine to five or have only an hour for lunch. Some of the challenge is therefore not about women's

knowledge but about supply and having access to professionals. Have you reached out to women to find out exactly what the issues are from their perspective, rather than from the perspective of health professionals and outcomes?

Professor Glasier: Yes, we have done that. Through the ALLIANCE—the Health and Social Care Alliance Scotland—we have had quite a lot of meetings with women with various health conditions. For example, here in the Parliament we have met women with endometriosis or PCOS, so we do hear from women. Apart from the availability of medicines in pharmacies, which is a specific issue with HRT, all the problems that you mentioned—such as having to make 25 phone calls to get an appointment with a GP—can happen to everyone.

Ruth Maguire: Is the main element of progress having the clinical expert on menopause, then?

Professor Glasier: It is that, but also the work with NES to improve information among primary care providers.

Ruth Maguire: How will we know that that approach has worked and has improved women's lives?

Professor Glasier: We should see fewer referrals to expert menopause services, because GPs should be able to deal with standard HRT.

Ruth Maguire: Are some health boards set up so that the route is not through GPs but through specific clinics for women? Is the situation the same across Scotland?

Professor Glasier: No, it is not the same across Scotland. For example, where I worked, in Lothian, the Chalmers sexual health centre, which is an integrated sexual health centre, had a thriving menopause service to which women could refer themselves, which was great. We are talking about what in England are called women's health hubs, but which we call integrated sexual and reproductive health services. The problem with that approach is that it tends to make life better for women who are able to get to the Chalmers centre and negotiate such treatment. There is also a danger that GPs will then say to a woman, "Just get yourself along to the specialist service", and then they stop providing basic menopause care. The danger of having women's health hubs is that we might deskill our GPs.

Ruth Maguire: You said that the measure of success would be fewer women being referred to specialist menopause services. Would there be value in measuring women's own experiences? The fact that someone is referred to a specialist does not necessarily mean that they will have a good outcome.

Professor Glasier: No, of course. In all our evaluations, and anything that we plan to do, we ask women about their experiences. We also ask providers about theirs, as well as trying to obtain a quantitative measure.

Ruth Maguire: Do you want to say anything about progress on the other two areas: endometriosis and heart health?

Professor Glasier: A lot of work is going on in relation to endometriosis. A lot of research is going on—particularly in Lothian—that the Scottish Government is funding.

I have a particular interest in heart health, partly because I have never done cardiology and it is always nice to learn something new, and partly because women are more likely to die of a heart attack than they are to die of breast cancer, for example. Through women's reproductive life course, there are reproductive health conditions that put them at increased risk of heart disease, and we do not currently use the opportunities to try to reduce that risk.

As an example, women with pre-eclampsia have an increased risk of hypertension and heart disease in later life. Maternity services are good at looking after such women but, as soon as a baby is born, the pre-eclampsia goes away, and so does the woman. Many women do not even have their blood pressure checked at the routine postnatal follow-up—if they have one—let alone being made aware that they are at increased risk of hypertension and heart disease in later life.

One thing that I am looking at is that, during Covid, when women were seen in maternity services with pregnancy-induced hypertension or pre-eclampsia, they were given a blood pressure machine to monitor their blood pressure and they did their own urinalysis, which was an effective way of monitoring their blood pressure during pregnancy. After the baby was born, the women were supposed to give the blood pressure machine back, which about half of them did.

I would like to reinstate that self-monitoring system; it has kept going in Lothian, but most health boards have stopped it. I would also like to take it further by asking women to keep the blood pressure machine, linking them to the Connect Me blood pressure website and sending them a text message or an email every six months to ask them to check their blood pressure. I am discussing with Professor Bhattacharya in Aberdeen whether we can do a study to look at the effectiveness of such an intervention at reducing the risk of heart disease in later life.

We are talking not just about pre-eclampsia but about PCOS, premature menopause and even recurrent miscarriage. All the women who are

affected could be linked into a system to reduce their risk of heart disease in later life.

Ruth Maguire: Is that holistic way of looking at things uniquely missing from women's health services or does it reflect how our health service operates in general?

Professor Glasier: Our health service has always operated in silos but, if we can improve the approach in women's health, maybe that will spread further.

The Convener: There are a couple of brief supplementaries before I come to Tess White.

Emma Harper: I have a quick supplementary to pick up on what Ruth Maguire said about menopause, endometriosis and PCOS. What work do you do or are you responsible for with women whose first language isnae English? How do we support them to have better care?

You work with the third sector, but I will ask about local authorities. I counted that seven of the 32 councils have a menopause plan. Are you responsible for supporting local authorities to raise awareness about menopause, for instance, with a plan?

Professor Glasier: I am not involved specifically with local authorities, but every health board now has a women's health lead who is supposed to work with the board executives to make sure that the plan's actions are being included in their work.

I think that I am right in saying that NHS Inform is available in a number of languages. There was something on the radio recently about a problem with interpreters, particularly in acute situations. There are issues for women whose first language is not English.

Sandesh Gulhane: I, too, will pick up on Ruth Maguire's point about menopause. Being a GP, I am lucky enough to go to multiple different practices. In my experience—although Ruth said that she does not like us giving examples—people in the better-off areas in which I work know about menopause. They come in, having done some reading and thought about it, and having decided that it is likely that that is what is going on. We then have a discussion about menopause, whether it is an appropriate diagnosis and what treatments may be appropriate.

Those from more deprived areas do not come in like that. I have not seen a huge shift in terms of women in deprived areas coming in with more knowledge about menopause. You said earlier that menopause is now more spoken of, but is that what we are seeing? Is that happening in better-off areas rather than in deprived areas? If that is the case, how do we get the message to those women in deprived areas?

Professor Glasier: I think that that is your job, as the GP. If you see a woman who is aged 45 to 55 and who comes in with insomnia or depression or something like that, and she does not raise the issue of the menopause, it is your job, as the GP, to say, "Well, this could be the menopause," and then ask specifically about other menopausal symptoms—about her menstrual periods and whether she is having flushes and sweats.

You are quite right—I think that women in deprived areas are less likely to raise these issues. If we look at the prescribing data, we see that women in deprived areas are less likely to be prescribed HRT. However, I think that it is the job of the GP, or the practice nurse, to say, "This could be the menopause" and open up the conversation from there.

Sandesh Gulhane: Sorry—forgive me, but a lot of women will not present because they are not aware that it could be menopause and that that is something that we could very easily treat.

Professor Glasier: But they present with other things, surely.

Sandesh Gulhane: Not necessarily.

Professor Glasier: So, if a woman of 45 comes to you and complains that she is not sleeping well, would you discuss with her the possibility that she may be menopausal? Because I would.

Sandesh Gulhane: Potentially. I suppose that the question is about getting that knowledge into communities that traditionally do not have it, so that they are better informed and are able to champion their own health.

Professor Glasier: Yes, but I do not know how you do that. How do you make sure that women who are living in deprived communities are better informed about the menopause?

We are planning a publicity campaign about the menopause that will take place next year, and we are having meetings to discuss how best to do that. There is a meeting this afternoon with the clinical reference group for the menopause network, to get its advice on what to include in a publicity campaign.

However, I do not know how well publicity campaigns affect certain areas of society or certain strata of the population. I suspect that someone is more likely to be aware of those publicity campaigns if they are in a less deprived area than if they are running around looking after their kids and sorting out their problems with the cost of living.

I do not know what you would do, but I think that it is the GP's job, when people come to see them, to raise menopause as a possibility.

Ruth Maguire: I get a little bit concerned when we talk about women in deprived areas being less knowledgeable. In my experience as an MSP who represents some areas that are very economically deprived, the issue is not women's lack of knowledge or confidence. It is simply more challenging for someone to interact with a system if they are an employee rather than self-employed or if they are in a low-income job, or—as you said, Professor Glasier—if they have children to look after and different demands on their time. I just want to reflect—as you did in your answer, to be fair—that it would be quite a dangerous and lazy assumption for us to make in talking about women's health.

Professor Glasier: I think that that is right. As I said, if someone is busy looking after 101 things, perhaps they do not take so much notice of their menopausal symptoms.

Tess White: Shortly after you came into post, Professor Glasier, we had a cross-party group on endometriosis, as you may remember. The women's health plan has committed to reducing waiting times for diagnosing endometriosis from more than eight years to less than 12 months by the end of the parliamentary session. Is that achievable?

11:15

Professor Glasier: I hope that it is achievable, but I know that there are long waiting lists. To make a definitive diagnosis of endometriosis needs a diagnostic laparoscopy, because we need to see the endometriotic deposits. Most doctors are reluctant to submit people to a diagnostic laparoscopy, because it involves a general anaesthetic, and they have to overcome that. As you know, there is also a long waiting list for people with gynaecological conditions that are not cancer. Whether that situation will improve by the end of the parliamentary session, I do not know, but I hope that it will. The Scottish Government is putting money into waiting lists initiatives. The answer is that I hope so.

We are planning a publicity campaign on endometriosis—and I met the marketing people last week. The publicity campaign will be for healthcare professionals, not for women. The marketing people were asking me, "What would be your single message to healthcare practitioners?" I spoke about listening to women with endometriosis talking about their experience, and my single message to practitioners would be, "One in 10 women has endometriosis, and they would like to know that you are thinking about it as a possible diagnosis."

Tess White: The issue is the referral—women are saying to me that they are just not being referred.

Professor Glasier: I think that it is about the referral, but it is also important for a practitioner to explain to women that they are suggesting a particular form of treatment because it is valuable in treating endometriosis. A lot of women feel that they are being fobbed off when GPs put them on the pill. I am a great proponent of the pill, which I think is a great treatment for heavy menstrual periods, for example, and those who take the pill continuously do not have periods, so they do not have dysmenorrhoea. However, GPs need to explain to women why they are putting them on the pill, so that they do not feel fobbed off. If women have systems suggestive of endometriosis, healthcare professionals should tell them that they are considering the diagnosis of endometriosis and will refer them if their symptoms do not settle on the standard treatments.

Tess White: We know that there are an estimated 100,000 women living with endometriosis in Scotland. The view of Endometriosis UK, based on the data, is that the base level of care for this debilitating condition is currently not being met across Scotland. What action would you propose to improve the situation for all those women?

Professor Glasier: We need to work our way through the waiting list, so that women wait a shorter time before they are seen by a specialist with an interest in endometriosis.

Tess White: You have talked about heart health as being the highest priority. Would you say that endometriosis comes a close second?

Professor Glasier: I would not, no. I do not think that endometriosis is worse than many other conditions. We hear a lot about endometriosis because the people with endometriosis have done a very good job of getting their advocacy going. There is a national endometriosis society that is now called Endometriosis UK that is speaking very well for women with endometriosis, but I would not put it just below heart disease. I might put breast cancer quite high up, and ovarian cancer.

Tess White: I would just like to say that the women who were talking to me, and those who shared their stories with you at the CPG, have spoken about debilitating pain, breakdown of relationships including marriage and not being able to work. That is not because of the lobby group; it is because of the huge amount of issues that the women are having.

Professor Glasier: I know, and I agree with that. It is very moving to hear those people talking about their experiences with endometriosis, but

this is not just about women with endometriosis. There are a lot of conditions that make women's lives extremely difficult, and we should do better at tackling all of them.

The difficult thing with endometriosis is that it is a difficult condition to diagnose without doing surgery, and doctors try to avoid doing surgery because it involves a general anaesthetic, which takes time, and because there is a long waiting list for surgical procedures.

Carol Mochan: Good morning. I have been interested to hear your reflections on working in a different way and on attitudes to approaching women's health. It is helpful to hear you talk about that.

My question is on funding. I am interested to know whether you have any reflections on how funding is used to support women's health; whether the plan has enough funding attached to it; and whether there is anything that you think we might have to fund to get it right, such as the training and so on that you talked about.

Professor Glasier: Of course I would say that there is not enough funding behind the women's health plan—I would be mad not to. Yes, could we have some more money, please? That would be very nice.

I give the example of long-acting reversible contraception—LARC—methods, such as intrauterine devices and contraceptive implants. Abortion rates have increased by 19 per cent, which is nearly one in five pregnancies, between 2021 and 2022, and it is likely that they will go up again this year.

We know that IUDs and implants are by far the most effective methods of contraception; they have failure rates of less than 1 per cent in comparison with the failure rate for the pill, which is 9 per cent, or for condoms, which is 18 per cent. They are also much more likely to be continued than the other methods, because you have to go and see somebody in order to stop using them, so inertia acts in favour of continuation.

However, we know that we are not nearly meeting the demand for long-acting reversible methods of contraception. We know that many GPs have stopped providing such methods, in particular IUDs, because they are overwhelmed and they do not have the capacity to do so. It takes three appointments, plus it takes up to three appointments for the assistant as well. Although the method lasts for at least five years, so I would see it as a good investment of time, GPs who are faced with hordes of people coming in to be seen with 101 different conditions do not see it in the same light as I do.

We know that sexual and reproductive health services are not meeting the demand. Yes, we need more money for long-acting reversible methods of contraception.

Carol Mochan: How are you, as the women's health champion, approaching that with the Government? Have you spoken to it about where the funding might come in, or where we might move money from?

Professor Glasier: We set up a short-life working group to understand why we are not meeting the demand and to look at options for how to do things differently. In a couple of health boards, people have looked at cluster arrangements. For example, one GP who is skilled at inserting IUDs—to go back to IUDs—and is passionate about doing so provides a service for half a dozen different practices. That works there, but all the initiatives that we have looked at have been funded by soft money, and they depend on one individual person, so they are not sustainable.

I have spoken to the people in St Andrew's house about the GP contract and whether—this is probably a very unacceptable thing to say—we could move money from the GPs who are not doing LARC any more to sexual health services, so that they are providing LARC.

I have been told that that cannot happen. I am, therefore, just now finalising a paper that says, "This is the bottom line: health boards have to accept that, if they want to reduce unintended pregnancies and abortion rates, they should fund LARC." I am going to tout that around everybody I can think of—the chief medical officer, the deputy chief medical officer, the national clinical director and the minister—and try to put pressure on whomever, so that boards fund it.

Carol Mochan: You talked about training staff so that they approach women's health in the right way. Do you think that there is enough finance in the system to do that, with regard to primary care, GP practices and so on?

Professor Glasier: Actually, I do not think that that is not so much an issue of finance; it is about thinking differently. I will give you another brief example: the insertion of an intrauterine device when somebody has just had a baby. If somebody has decided that they would like an IUD as a postpartum method of contraception, the best time to insert it is immediately after the baby is delivered. Baby out; placenta out; IUD in.

I think that it needs to be the responsibility of the person who is doing the delivery to put in the IUD, regardless of the mode of delivery. If it is a consultant doing a caesarean section, they should put in an IUD at the time of the caesarean section, and they are doing that now in Scotland. We have achieved that. I think that it is true to say that, if

you are a woman who wants an IUD as an immediate postpartum contraceptive, it will be done if you have an elective caesarean section. We are not quite so good at doing it immediately after a forceps or ventouse delivery, and we are very bad at doing it after a spontaneous vagina delivery.

What we need is for the Royal College of Midwives to put IUD insertion on the curriculum for midwives in training. That is not about money but about getting people to think differently about our responsibilities for women's health. It is about getting GPs to ask women who are aged 45 whether they have any menopausal symptoms. It is about getting people to think differently.

Carol Mochan: That is lovely. Thanks very much for your time.

Tess White: One in five women will experience perinatal mental health problems and suicide is, tragically, the leading cause of maternal death in the first year after a baby's birth. Would you support perinatal mental health being addressed as a priority in the next women's health plan?

Professor Glasier: I would need to discuss that with stakeholders. Personally, I think that that probably sits better in the maternity plan than in the women's health plan, because it is all part of maternity—that is, unless we amalgamate maternity and women's health, which I am not sure would be a good idea.

I would need to discuss that with whichever stakeholders we are going to discuss the next iteration of the plan with. However, I suspect that it is better for perinatal mental health to stay in the maternity plan.

Tess White: Do we need better and more support for perinatal mental health?

Professor Glasier: Yes, I am sure that we do.

Tess White: Thank you.

Too many women have described to me the dismissive way that they have been and are being treated by clinicians. It is almost as though that is a culture. That experience ranges from menopause to endometriosis. The committee has been given several serious examples in relation to the transvaginal mesh scandal. The women are not believed, which has an impact on their mental health. Have you seen, or are you being told about, any of that dismissive culture? If so, can anything be done about it?

Professor Glasier: I went to the group on endometriosis, and you hear about it there. However, I have to say that you hear only from those people who are unhappy with the way that they have been treated. I hear only from those people who are unhappy with the way that they have been treated; I do not hear from people who are happy with the way that they have been treated. That is always how it is. You hear from a very small and very biased sample of people, and I think that that colours your view.

I do not think that the majority of doctors are dismissive. The majority of doctors and nurses and everybody else in the national health service do their absolute utmost to provide a really good service.

Sometimes individuals are unhappy with the service that they have received and sometimes individuals do not hit it off with their healthcare provider, but I think—maybe the GP on the committee will agree with me—that people do their best and that people who are very unhappy with their care are very much in the minority. I am sure that we are all unhappy about having to phone at half past 8 in the morning to try to get an appointment but, when we are seen, I think that the majority of us are happy with the care that we get.

Paul Sweeney: I thank the witnesses for their comments so far.

I have a particular concern about the decrease in drugs deaths in 2022. I note that the reduction was far greater in males and that there are evidently particular issues in relation to women who use drugs that mean that their rate is not decreasing at the same level. Do you have a view on why that might be the case and what might be done about it?

11:30

Professor Glasier: No. I am not an expert on drug abuse. I read the papers, but I would have to defer to the people who work in that area. I do not think that I can say anything helpful about that. We recognise in the women's health plan that women's health—everybody's health—is intersectional and that there are a lot of things going on in people's lives, but that is not my area.

Paul Sweeney: Does either of the officials have any comments?

Greig Chalmers (Scottish Government): I do not think that we would want to add to what Professor Glasier said. However, it goes without saying that, if any issues come up during the session that you think engage Government policy, we can provide some clarification in writing, if that would help.

Paul Sweeney: Audit Scotland told the Public Audit Committee in September that the mental health transition and recovery plan, which prioritised the mental health of women and girls, did not outline timescales for the actions and that a review of progress had not been carried out.

Professor Glasier, is that on your radar as women's health champion? Do you support calls for further detail on delivery and evaluation?

Professor Glasier: What was the last bit? Do I support—

Paul Sweeney: Do you support calls for further detail on delivery and evaluation?

Professor Glasier: Of mental health?

Paul Sweeney: Yes.

Professor Glasier: In general, yes. The women's health plan recognises that mental health impacts on women's health and that women's health impacts on their mental health. We know that menstrual problems and the menopause affect women's health. Through the specific issues and actions in the women's health plan, we are trying to deal with that.

Paul Sweeney: You mentioned that you do not have a particular locus on drug deaths. Do you have a particular locus on alcohol-related deaths?

Professor Glasier: No, I do not. That does not appear in the women's health plan.

The Convener: We will move on to the next theme, which I believe Mr Sweeney has questions on.

Paul Sweeney: I do indeed.

I am a former member of the Citizen Participation and Public Petitions Committee, which quite regularly receives petitions relating to women's health. Petitions on smear-test age, fertility treatment and abortion are currently being considered by that committee. Professor Glasier, what are you doing to ensure that women's concerns about issues such as those raised by petitioners through the Citizen Participation and Public Petitions Committee are being addressed by the Scottish Government, the national health service and local government?

Professor Glasier: As you know, we are doing a lot of work on abortion and smear tests. The issue of infertility is not in the women's health plan, but I know that a group is looking at infertility services. There is a lot going on. I meet the abortion team quite regularly, and I am very interested in hearing what is going on with the work on late abortions and safe access zones, and hopefully, at some point, on decriminalisation of abortion. I think that the Scottish Government is pretty responsive to those topics.

Paul Sweeney: That is helpful. Do you have any engagement with those petitions?

Professor Glasier: Not specifically with the petitions, but I am working quite closely with the abortion team, because I have had a lot of experience with abortion and I have done a lot of research on the issue in the past. That and contraception overlap significantly with the women's health plan.

Paul Sweeney: Our previous evidence session was on remote and rural healthcare. It is clear that there are inequalities in accessing healthcare in Scotland not only on a geographical basis but on the basis of socioeconomic background. What does the women's health champion do to raise awareness of health inequalities and ultimately reduce them?

Professor Glasier: We discuss them in everything that we talk about. For example, in our menstrual health network, clinical network, menopause clinical network and with the women's health leads, we wave at them the women's health plan, which discusses inequalities, and we talk to them about their awareness of the impact of inequalities on women's health. As I said earlier, we have a proposal to do a pilot study in the deep-end practices to see whether we can do better at having a more holistic approach to women's health and in taking more expertise in women's health to women in those areas of inequalities. I think that we are trying hard.

Paul Sweeney: That is helpful.

There was recently a debate in the Scottish Parliament on protecting an award-winning neonatal unit in University hospital Wishaw. There are concerns about a lack of consultation prior to the decision being made on downgrading the unit, particularly in relation to mothers being separated from their premature babies. What can we do to ensure that local women who have those deep, emotional and upsetting concerns are consulted on decisions that impact them in an intense and visceral way?

Professor Glasier: Again, I am not concerned with the day-to-day work of the maternity plan or issues in neonatal units. Clearly, that is an issue, and I am sure that those women's voices are being heard, but I really cannot comment on that.

Emma Harper: Some of my questions on implementation and evaluation have already been covered. I am looking at the interim report from August 2023, which, obviously, covers the progress that has been made. I am interested in how you see implementation and evaluation going forward. I know that you do quarterly blogs. I know that there is a lot going on—I find it amazing just looking at the subjects being covered in the Citizen Participation and Public Petitions Committee and elsewhere—but how important is it to communicate the progress that is being made, so that people know what is being achieved?

Professor Glasier: You are absolutely right—we need to make people aware of the progress

that is being made. We need to make healthcare providers aware, too, because we hear all the time that people are demoralised. I think that demoralisation is a self-fulfilling prophecy so, whenever I meet groups, I always emphasise the positive. For example, we have a meeting this afternoon with the menopause network reference group to review what we have achieved in the past year and what we hope to achieve in the next year. We need to congratulate those people on what we have achieved, because we have achieved a lot.

Emma Harper: Do you think that there is a role for us, as MSPs, with regard to our connectivity on social media? Sometimes social media is not the best platform for communicating things, but social media could be used in a different, more positive way to support good communication. I was recently at an event in Dumfries and Galloway at which Dr Heather Currie spoke to 100 women in the room about the menopause. She is a total champion for destigmatising menopause and communicating an understanding about what it is all about. As MSPs, do we, too, have a role in communication?

Professor Glasier: Yes, I think so. It would be great if you could say some nice things about how well the women's health plan is going. It would be great, too, if you kept reminding people about NHS Inform and that, whenever they have a health condition that they want to find out about, they should go to NHS Inform rather than Google to get accurate information. In any case, it would be really great if you could be positive about the women's health plan.

Emma Harper: I am happy with that, convener.

The Convener: Finally, Gillian Mackay has a supplementary question.

Gillian Mackay: Professor Glasier, I was struck by your earlier comment about intersectionality versus the siloed way in which the NHS often works. I know that your priorities fall naturally into three large chunks, but how do you see them working across each other? Earlier, you highlighted the example of women with PCOS being at higher risk of heart disease; they are also at higher risk of diabetes and such conditions. Quite often, once you are diagnosed, you are given tablets that have wonderful side effects and are then left without any other form of follow-up. Are you and the team actively looking at such crossovers, and what progress is being made on some of those areas?

Professor Glasier: Yes, the team is looking at those things. Soon after I started, the team and I went to Aberdeen to meet NHS Grampian. You might know that it is going to open a new hospital in Aberdeen next year—the Baird family hospital. When I spoke to the non-executive director, she said that they really wanted to do things differently. As a result, we have been having discussions with the health board and the professor of obstetrics and gynaecology there, and we have put them in touch with Chest Heart & Stroke Scotland.

For example, I said to them, "Why don't you, in the waiting area of your nice new shiny hospital that will see a lot of women, have a women's health information hub?" People's blood pressure could be checked there; blood could be taken for cholesterol checks; women could be talked to about osteoporosis and so on. All of that could be done with volunteers from Chest Heart & Stroke Scotland—it does not have to cost the NHS money. I think that it is terribly important that we try to broaden our horizons and how we look at health in general and, for us, women's health in particular.

Gillian Mackay: That is great. Thanks, convener.

The Convener: I thank Professor Glasier and the officials who have joined her today for their evidence.

At next week's meeting, we will continue our inquiry into healthcare in remote and rural areas and hear from academics with expertise in rural healthcare.

That concludes the public part of our meeting.

11:40

Meeting continued in private until 12:20.

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