OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 12 December 2023

Session 6

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
38th 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:

Michael Dickson (Scottish Ambulance Service)
Nicola Gordon (Royal College of Nursing)
Jaki Lambert (Royal College of Midwives)
Dawn MacDonald (Unison)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 12 December 2023

[The Convener opened the meeting at 09:15]

Decisions on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 38th meeting in 2023 of the Health, Social Care and Sport Committee. I have received no apologies.

The first item on our agenda is to decide whether to take items 4 and 5 in private. Are members agreed?

Members *indicated agreement.*

Healthcare in Remote and Rural Areas

09:15

The Convener: Agenda item 2 is the fourth oral evidence session as part of the committee's inquiry into healthcare in remote and rural areas. We will hear from a panel of representatives of the healthcare workforce. I welcome Dawn MacDonald, who is Highland healthcare branch secretary at Unison; Jaki Lambert, who is the director for Scotland of the Royal College of Midwives; Nicola Gordon, who is policy manager for Scotland at the Royal College of Nursing; and Michael Dickson, who is the chief executive of the Scottish Ambulance Service. Jaki Lambert and Nicola Gordon are joining us online.

We move straight to questions and we will start with Ivan McKee.

Ivan McKee (Glasgow Provan) (SNP): Thank you, convener, and good morning to the witnesses who are here and those who are online. I want to focus on the proposed national centre for remote and rural health and care. How do you see that contributing to addressing the challenges that we face in remote and rural healthcare? What should be the priority for the national centre over its first few years? Is anyone willing to jump in and give a perspective on that to get us warmed up?

Dawn MacDonald (Unison): My perspective is that, certainly in remote and rural areas, we struggle because we have a lack of affordable housing. I cover the whole of NHS Highland and NHS Argyll and Bute, which is a land mass the size of Belgium. When people come to these areas, I do not think that they understand their rurality at first. They come back to us saying that they cannot afford to pay the rents that are being charged. As you will understand, in areas such as Islay and the 36 islands within NHS Highland, we do not have a lot of housing, so people can charge what they like, but national health service staff cannot afford those houses on the pay that they get.

What we definitely need in order to encourage people to come to Highland—I am talking not just about nurses, but about allied health professionals, junior doctors and so on—is affordable housing so that staff can come and bring their families to these areas.

Ivan McKee: I think that you are saying that, unless the national centre addresses that issue, other work that it does will be of limited value.

Dawn MacDonald: That is the bottom line. If we do not have the resources, which are the staff, where do we go from there?

Ivan McKee: Absolutely. Michael, do you have any thoughts on that?

Michael Dickson (Scottish Ambulance Service): Yes. The first thing is that it is not a numbers game. It is really easy to focus on the number of staff that we need, but actually, in the small teams that we find in rural locations, a difference of one or two people can be vast for sustainable services. If we lose a couple of people, it can destabilise the whole team. More people are likely to say, "Actually, this isn't right for me".

For me, the focus has to be making "remote and rural" a badge of honour and putting it front and centre of what the work of health and social care looks like moving forward. It is a huge privilege to work in these communities. It is a massive opportunity for people to see a breadth of activity that they simply will not get to see if they work in a city centre location or in the central belt, and we need to harness that.

We have worked with a former chief executive of NHS Shetland and we have seen some really good work there. We also have the "Rediscover the joy of general practice" project, which is about allowing people to strike a different balance in their work life. After the pandemic, we are not all chained to our desks from 9 to 5. People want to do different and exciting things, be it in the rest of Scotland, the rest of the United Kingdom or even globally, and we can offer flexible opportunities for people to explore new and exciting career opportunities that they may not have considered before. For me, the focus has to be the offer for people who are considering working in remote and rural healthcare.

Ivan McKee: That is very helpful. You have talked about the opportunities, and about turning into positives some things that are often portrayed as negatives.

Do the witnesses who are joining us online—Jaki Lambert and Nicola Gordon—want to comment?

Jaki Lambert (Royal College of Midwives): There is remote and rural provision across Scotland, but it is often at the side of other health boards, so it does not get priority. It does not get seen. Often, the same metrics are applied to remote and rural areas and to the central belt. We need to look at remote and rural services in the round and be able to provide a service that is not related to case load or population size, so that these areas are not disadvantaged. There are a lot of remote and rural areas across Scotland, and predictions are based on their reduced population size. However, that does not mean that people do not still require a service. We must make sure that we provide what is required in order to provide the right service for families in those areas, rather than looking only at the case-load size and reducing the NHS Scotland resource allocation committee allowance accordingly, because that reduces the ability to provide that care.

I echo Dawn MacDonald's point about housing. As an example, I know that two midwives were happy to take jobs on Skye. They wanted to work there, but they could not get accommodation, so they could not do it. Housing is a huge issue—not just for the workforce coming into the area, but for students, who are unable to afford to take up placements in remote and rural areas. That has a great impact on the ability to recruit. I have been a midwife working full-time in Argyll and Bute for 20 years and I know that the ability to bring students in and show them the amazing roles that can be undertaken in remote and rural areas is restricted.

We often hear the idea that, if people go into the remote and rural workforce, they risk being deskilled. As Michael Dickson said, we need to turn that round. Actually, the skills that are required in remote and rural areas are often much broader. We work to what would be an advanced level if such a level of practice was recognised in maternity care. I talked to midwives in the Western Isles and Orkney yesterday and, in order to provide the right care, they undertake roles that are not undertaken on the mainland. Recognising the roles and enhancing the voice of remote and rural provision is key, rather than it just being seen as something that is on the edge of other health boards. It is also key to look at what is required to provide the service, rather than looking only at the case load numbers.

Nicola Gordon (Royal College of Nursing): I agree with everything that Dawn MacDonald, Michael Dickson and Jaki Lambert have said.

The remit of the national centre will be important because, as the committee has heard, remote and rural provision is a wide issue that goes well beyond health and social care. It is also about housing, transport and the complexity of access to services in what are massive and very remote geographical areas. Caring for people in remote and rural communities is challenging. There also needs to be recognition that care in the community is quite prevalent in remote and rural areas. They often have older populations with increasingly complex needs and we need to understand where investment is required.

We must also ensure that the work of the new centre links with all the other work that is already going on in the Scottish Government. A number of centres and initiatives are addressing workforce challenges. It is also important that the centre is linked to the ministerial task force on nursing and midwifery so that we do not end up with a number

of disparate programmes that are not well connected.

Ivan McKee: Thank you for your answers. The next thing that I want to focus on is the scope and potential for innovation. What role should the centre play in driving innovative solutions and ways of organising and delivering services? Michael, I see you nodding, so I will bring you in first.

Michael Dickson: If you want to see innovation in practice, you should go to a remote and rural location, because communities in those places—it is not just the professionals—come together and overcome the huge challenges that they face. As I have said before, it is such a privilege to work in that environment, and it is such a privilege to live in that space, which is why other issues such as housing and transport are so critical.

There is a wealth of innovation taking place. Where we often struggle is in sharing that. We can take quite a protectionist approach to the practice that occurs. We are all different but, actually, we are all facing very similar challenges, so we need to put that aside and ask how we can spread the innovation that exists across the piece.

The next piece is about a multiprofessional approach that has the patient at the very centre of how we work. That is fundamental. Traditional roles are rapidly changing. I am a nurse by profession, and the innovation that is taking place within nursing right now means that it is light years ahead of where it was when I trained. In the ambulance sector, we have a really fortunate opportunity whereby we can extend our skills even further and work in a range of sectors that are outside the normal confines of an ambulance service, from primary care through to urgent and emergency care. That is all innovation. It is all about shifting, working with the third sector and working with community organisations.

The challenge for us, as healthcare professionals, is that we have to let go of some of the traditional models that we have got used to over many years. We have to embrace that and say, "We will have to share some risk with the patient, and that's okay". The approach presents a really important opportunity to share learning and think about completely different ways of working.

Ivan McKee: Does the centre need to see working in that space as one of its core missions?

Michael Dickson: Yes, but it is not just about the centre. For the approach to be effective, the whole of the NHS in Scotland needs to embrace that innovation. There is often a view—it was mentioned a few moments ago—that innovation will not be applicable unless it has come from the central belt. Actually, in places such as Shetland, which I mentioned before, there is rapid adoption of innovative models that can then be scaled back up to be demonstrated across the whole of Scotland, rather than the other way round. We do not need big-scale models to deliver real and rapid change.

Ivan McKee: Does anyone else want to comment on the point about innovation?

Dawn MacDonald: I am thinking about the structure that we have. We do not have the benefits of big urban hospitals. My background is in nursing. A lot of our nurses have taken on what are classed as generalised skills, but they are not really that; they are really good skills, and they are complex skills.

I worked in accident and emergency in Inverclyde, and then I moved to Bute. I have worked in A and E and on the wards, and latterly I worked out in the community for 10 years. We have to have a lot of skills because we do not have those wraparound services. We stand alone. I come from the Isle of Bute, and it has nurses who are on their tod until a GP comes in. They have to look after patients on their own, so they need to have those skills The problem is that they are seen as generalised skills, which is wrong. That is the biggest issue that I hear from members, who say, "We have all these skills and we use them."

When I worked in Inverclyde, I would press a bleep and somebody would come down and do an electrocardiogram. I would press another bleep and somebody would take bloods. In rural areas, we do all that, so we need to have those skills, but that is not recognised in pay. Nurses are working to those levels, but they are not being recognised for it, so they leave because it is easier to go and work in an urban hospital where there are wraparound services. They get the banding, but they are not doing half the specialised work that staff in rural areas do.

09:30

Jaki Lambert: As Michael Dickson said, remote and rural areas are very good at innovating, but there are challenges in the links to the central belt. For example, NHS Near Me was introduced in remote and rural areas way before it was introduced anywhere else. We were able to provide consultant appointments in women's homes, sitting beside them, way before that was done in the central belt and way before Covid. The challenge has often been in getting engagement from the central belt to be the other side of those links.

That is also the case in relation to scanning services, which have been developed in remote and rural areas because people do not want to, or are unable to, travel to the central belt. The most

vulnerable families are the least able to travel, so they are the ones who are often denied access to care.

Services are developed, but getting access to the training or practice placements in the central belt to enable staff to develop the skills that are required can often be a challenge. There is no lack of innovation, but there is often a lack of access to what is required to make sure that the services can be developed and sustained.

There is another issue. I know from what I hear when I go round community maternity units across Scotland that, often, no wi-fi is accessible in the maternity unit even though there are electronic records. Basic infrastructure to enable innovation is lacking.

There is innovation in how education is provided. The idea that people have to go to Aberdeen, Edinburgh or Glasgow to be educated is dated. It is important that people can earn and learn where they live, because they are much more likely to stay in the area if they do not go away to train. However, for that model to work and for standards to be maintained requires the right infrastructure and recognition of the need for educators and academics to live and develop their work in remote and rural areas. It is not just about people being able to earn as they learn; it is also about the ability to provide career structures for people so that they remain in remote and rural areas.

There is no lack of innovation, but there is often a lack of investment in the ability to take things forward.

Ivan McKee: Nicola, do you want to comment?

Nicola Gordon: Yes. We are looking at innovation in technology and technological advances, but also at innovative clinical practice and patient care. The intersection of those things is really important.

I agree with the points that Jaki Lambert made about education, training, career development and looking at new models or different things. We know that we have an issue to do with retention in the workforce. What do we do once we attract people post-qualification in nursing and midwifery? Where do they go? Remote and rural areas have some particular challenges around progression opportunities. There are a number of things there that can be looked at through the task force.

With Covid, we have seen that harnessing the power of technology has made a massive difference to patient care in remote and rural areas, but there is always more that can be done. There are particular issues to do with funding. That is understandable, but they need to be looked at by the centre. It should also look at training and backfill to ensure that staff feel competent and capable in using the technologies. Another important issue is the balance of care. How do we educate our communities so that they feel confident about the care that they receive remotely, whether that is digital first appointments or other things? How does that fit with what people need and expect from services?

We also need to look beyond the NHS to the independent health and social care sector. That is increasingly important because of the complexity of needs of those who are receiving social care, so I would like to ensure that we capture that in the mix.

Ivan McKee: Thanks very much. You have opened a lot of doors in your comments and I am sure that other members of the committee will want to investigate them further.

Ruth Maguire (Cunninghame South) (SNP): Thank you, convener. I have a quick supplementary to Ivan McKee's question. Michael Dickson twice mentioned Shetland and innovation. What is it about Shetland that has enabled it to innovate in the way that you have described?

Michael Dickson: That predates my role as chief executive. A number of years ago, various community leaders got together and said—this has existed in Shetland for a long time and I apologise to the politicians in the room—"Politics will always change, but we have to do the right thing for the people of Shetland." That is about kicking boundaries down. It makes no difference who employs you or what badge you wear; you are part of the community. That drives how everything operates in Shetland. It drove our approach to Covid—

Ruth Maguire: Can I just check with you, is there one health board and one health and social care partnership?

Michael Dickson: There is one health board, one health and social care partnership and one local authority. People will say, "Well, it must be easy then," but we have exactly the same challenges. I say "we"; I am no longer in Shetland, I hasten to add. There is a fantastic team there. The teams there face the same challenges with housing and recruitment as are faced everywhere else, but it is about putting the people in the community at the forefront of the decision-making processes and Shetland is in stark contrast to other remote and rural locations.

Out Skerries are the furthest away islands and have a very small community. We tried on a number of occasions to recruit a nurse and failed each and every time, for a range of reasons. A nurse there would serve a tiny population of between six and 50 people, depending on the weather and the month of the year. How do we

sustain someone's skills during that time? How do we get that to be an effective and attractive role?

We engaged with the community and asked them what their biggest concern was and what would work best for them. The biggest concern was what would happen in the event of an emergency. Who should they speak to? The particular profile of the Out Skerries means that there is no runway, which means a helicopter transfer.

We discussed basing a healthcare assistant there and we had the idea of presenting it as, "Come and live on a tropical island, you and your partner." You will have seen the kind of advert that is about the principle of someone making a difference in a community. That has been massively successful and the community really embraced that person.

Again, it is about looking at things from a different angle and stepping away from the traditional but, fundamentally, the first question that you ask is what you need to do to protect and sustain your community. The close working relationship, which does not require organisational change, is fundamentally about doing the right thing for Shetland wherever you are employed—in the Council, the third sector or the NHS—and it is pivotal.

Ruth Maguire: Okay. Thank you. That is helpful.

Emma Harper (South Scotland) (SNP): Thanks, convener and good morning to you all.

I will pick up on innovation, but also link it to advocacy for communities—the staff as well as the people who are receiving the care. Is there a role for the new national centre to advocate for the people in the communities? One of the submissions was from Dr Gordon Baird on behalf of Caithness Health Action team, the "Save our services" campaign on the Isle of Skye, and Galloway community hospital action group. Dr Baird wrote that he was

"hoping to work with the new centre to provide information and understanding of national and regional issues and prevent ineffective repetition through feedback on the effectiveness of local solutions."

Throughout his submission, I am thinking that the word "advocacy" is a part of that. Would you support that being part of the work of the national centre?

Dawn MacDonald: Yes, absolutely. That is what we need. We need that voice and support to come out into the community. In remote and rural areas, as Michael Dickson and others have said, it is not just about the hospital setting. It is also about what is out in the community. We need people in there to be able to have that voice to help us move forward with what we need in these areas.

Emma Harper: I forgot to remind the panel that I was a clinical educator in a remote and rural area delivering what you are talking about—ECG, blood draw and things like that. It was part of my job. I forgot to remind colleagues and the panel about that. Thanks.

Sandesh Gulhane (Glasgow) (Con): Thank you, convener. I declare my interest as a practising NHS GP.

There is a lot of clarity in what has been said, particularly by Nicola Gordon, who spoke about the remit of the national centre. Does the panel feel that the national centre's remit, as it is set out right now, will significantly address the key issues facing workforce recruitment and retention in rural areas?

Michael Dickson: I think that there is a risk—going back to Ms Harper's question a moment ago—that we see this as the solution to everything. "Oh, it will fix that. It needs to be adequate for that. It needs to pick this up." We have to recognise that there are many organisations involved in rural healthcare. It is not limited to the NHS; it includes social care and links into local authorities and housing. I have mentioned previously that if you wish to come and work in the NHS in Scotland you need to apply 22 times to be able to work in every single board. There is an opportunity to easily overcome that by having a single way to be able to join the NHS in Scotland.

The risk is that the centre becomes the one solution, and then, to reflect on the comments that were made from Caithness, it becomes yet another duplication because it is trying to do absolutely everything. I would advocate that it has to be very focused on the aims and opportunities that it can embrace, rather than trying to be the broadest possible thing. Then we will see that the delivery it can do would be relatively limited.

Tacking back to Shetland, I think that it is fundamentally about taking a clear role but knowing that it has a critical relationship with other key partners that work across the system and not trying to do everything.

The Convener: I believe that Jaki wants to come in on this too.

Jaki Lambert: I think that the remit is not 100 per cent clear, but I suppose it is about being able to look at what is important. There is a real risk that people start to say, "Oh, well, that will be for the centre to sort," rather than ensuring and amplifying that remote and rural healthcare needs to be considered within all areas that are being looked at; that was highlighted very clearly within

the task force, as Nicola Gordon mentioned earlier.

However, there is something about being able to promote that anchor institution idea—that there should be NHS and care facilities in remote and rural areas. While there is innovation around substitution, there is also a risk. We should be promoting skill and the provision of a higher level of care, not just the expectation that if you live in a remote and rural area you will make do with a lesser health service.

If we want anchor institutions, we need to look at how they impact on the population's health. They have an impact because they have a workforce that lives and works there. I have joined the meeting from where I live, and I am sitting 10 miles from the nearest shop. What makes people come back to live in Argyll and Bute is that there are jobs and opportunities. You can be born here. You can live here. You can go to school here. If we keep reducing what is available, we will not have services and the falling population prediction will be a self-fulfilling prophecy. The centre needs to be the advocate in all spaces—[*Inaudible*.]

The Convener: We have lost you. I think that you are muted again.

Jaki Lambert: The centre needs to be the place that amplifies, rather than the place that becomes a dumping ground for anything to do with remote and rural.

The Convener: Nicola Gordon, you wanted to come in, too.

09:45

Nicola Gordon: Thank you. I absolutely agree with what Michael Dickson and Jaki Lambert have said. The problems are quite complex and long standing and precisely which problems the centre is trying to solve will need careful consideration. There is a risk that the remit could convey an impression that the centre is the route to solve all the workforce and other challenges. However, the problem is a bit bigger than that, so we need to narrow the remit down. I agree with Jaki that it would be helpful to better understand exactly what the centre's remit will be.

I think that it was Dawn MacDonald who mentioned at the start of the session that the key to all this is the workforce. We need in remote and rural communities a motivated, highly skilled and fairly paid workforce who have access to good permanent housing and who are confident that they have sustainable transport, good schooling options, childcare options and so on. The challenge is complex and wide-ranging and potentially there is a risk, as Jaki said, that the centre could be seen as a little bit of a catch-all or a dumping ground to solve all the issues. We need to be careful that it is not set up to fail.

Sandesh Gulhane: It is quite clear from what the panel has said that we should be finding out from the minister exactly what the centre's remit is and then we can certainly ask you and further panellists whether that is appropriate.

I heard Michael Dickson say that it should be "a badge of honour" to work in remote and rural areas. While I commend everyone who chooses to work in the NHS, and especially those going out to rural areas, that is surely not enough. Do we not need to incentivise people to go out and work in remote and rural areas and try to grab people from other areas to come into Scotland, or even those in the central belt to relocate, so that we increase the number of people coming in rather than try to move people who are already in the area? My question is about incentivisation.

Michael Dickson: There is a mixed model. If you look at comparable roles across the world, the Australian Royal Flying Doctor Service is an example that is not incentivised in that way. People choose to work there because it broadens their skill set. It gives them an opportunity, but it also means that, when they finish their time in that service, they can take that skill set back into the city centre location. It is not just about financial incentives. It is also about broadening your range, your remit, your skill base and then taking that back to your core role. Again, it is a challenge to do that within Scotland. Working across different organisations can be difficult. That is something that could be made far easier just by the way in which we recruit people.

Also, the people have to be the right people. They have to want to work in those communities. They have to want to work in a rural location. We certainly find that when people go and work in a remote setting, be that in an island or in one of the Highland areas, it is apparent quite quickly that it is either for them or it is not. I arrived in Shetland in January and I was saying, "Wow, it is really dark all the time." It is not unreasonable that people have not necessarily considered that. They may not have factored in that it is incredibly expensive to heat their house in Shetland because it is all electric—and we are all aware of the on-going challenge of the cost of energy. Someone may not have thought those things through and, while Shetland is beautiful, it is not for everyone. We have to be pragmatic.

That is why I think that we should be saying that it is an opportunity, that you can go over there and experience it. That is why the GP joy project—"Rediscover the joy of general practice"—is so interesting. It gives people the chance to taste what it is like living in those communities and then

say, “Actually, yes, I have really enjoyed this. I would consider a permanent role.”

I hope that you managed to get up to Shetland to do a shift. The last time that we spoke, you were looking to do that.

Sandesh Gulhane: *[Inaudible.]*

Dawn MacDonald: From my perspective, we need to get back to basics. If we want to incentivise people to come to these areas, first, we need to have housing there to provide for them. Secondly, we need to look at the pay structures that are in place if we want to incentivise people to come and stay. As my colleague Michael Dickson said, we do not have the competition that you have in Edinburgh and Glasgow. We are in small rural areas where things are more expensive to buy.

We also need to look at progression. When you come up to the rural areas or you are working in small islands, you cannot progress from a band 5 to a band 6 and 7 as you can in the urban areas, such as Inverclyde or Glasgow or Edinburgh. You may stay at band 5 for the whole of your career. That does not help people because they get to a point where they get fed up and they want to move away to get better pay and move up that banding.

We need to look at progressing from band 5 to band 6 because a lot of my members are band 5s and have been for 20-odd years. It is also about services. If we want people to come and stay in rural areas, we have to have services correct. We have to be able to wrap around these people. Mental health is a massive issue within Argyll and Bute: the services are almost non-existent and we struggle constantly with mental health care. It is important to have access to proper services.

If you are bringing your family, you want to be sure that you can access services when you need them, such as paediatricians for your children. We struggle to recruit and retain those services within NHS Highland. I believe that one reason for that is that we are the only model in the whole of Scotland that has a lead agency in NHS Highland and a body corporate integration joint board in Argyll and Bute and that in itself brings complexities to people joining NHS Highland.

The Convener: Ruth Maguire will move on to our next theme. We have a lot of ground to cover, so I ask the witnesses to be concise in their answers, please. That would be really helpful.

Ruth Maguire: Good morning, everybody. I want to ask about multidisciplinary teams. I will go to Dawn MacDonald first.

The role of multidisciplinary teams will be different in remote, rural and island communities. Let us look at Highland as an area. Dawn MacDonald talked about the Isle of Bute. That is closer to me in Ayrshire than it is to Inverness, where her health board is. There will be different needs there. Can you speak about the different teams and give us a flavour of that?

Dawn MacDonald: Absolutely. We have a lot of teams that cover the whole of Argyll and Bute and the NHS Highland area. Covid was a terrible thing to happen, but it opened our eyes to Microsoft Teams. People can now get access through digital means to multidisciplinary meetings around the table. We struggled to get such meetings before because of diaries and people having to travel, for example. As you have said, the area is massive. Microsoft Teams has been absolutely fantastic for that. There is also access through NHS Near Me—Jaki Lambert talked about that. Digital works for us in a multidisciplinary way of working, and we need that because of our geographical layout.

Ruth Maguire: Are there challenges? Michael Dickson spoke about Shetland. There could be a more compact area with a health board, a local authority and a health and social care partnership—I appreciate that there is space between the islands. Perhaps there is more of a challenge in getting the services in the Highland area. You have spoken about NHS Highland in Inverness and the IJB in Argyll and Bute. Are there challenges in innovating and recruiting with that?

Dawn MacDonald: Absolutely. NHS Highland is the employer for all NHS workers, and there is the IJB in Argyll and Bute. Although NHS workers are part of that health and social care partnership, there is a bit of complexity around that and the fact that the IJB makes decisions, but we have employees who work for NHS Highland. People get really confused about the what, where and when, the policies and what they cover. It is a massive area to cover. When we bring people to those areas, we need to be specific about what their jobs can look like. Somebody in Fort William might have to cover Argyll and Bute.

Ruth Maguire: We speak about urban policies being implemented in remote, rural and island communities. Would you say that the challenge is not necessarily in policies from Glasgow or Edinburgh, but is sometimes in trying to apply policies from Inverness or Fort William?

Dawn MacDonald: Absolutely.

Ruth Maguire: Jaki Lambert mentioned remote and island areas being far removed from health boards. Do you want to say a little more about that?

Jaki Lambert: Yes. As you know, there are IJBs across Scotland, but the Government very much talks to health boards. I will talk about Highland, as I have spent a lot of time there. I have lived and worked in Argyll and Bute.

The multidisciplinary team is in Glasgow. As Dawn MacDonald said, Microsoft Teams, for example, makes it possible to have discussions, but there is a real disadvantage for Argyll and Bute because there is much more resource and investment in structures in the north and in Highland. Argyll and Bute is often very much the poor relation in that respect.

A lot of amazing innovation goes on, but there are real challenges in that space with that disconnect. We talk about multidisciplinary teams in maternity services. The way of working with children and families and maternity services working hand in hand is exemplary. That is what we want around families, but that is invisible in many ways. There are real challenges when directives come out to health boards directly from the Scottish Government. The daily work goes on in integrated spaces, such as Argyll and Bute and Shetland, but things can be very difficult because the policies do not always match up.

Ruth Maguire: Jaki Lambert mentioned that midwives are very much part of the multidisciplinary teams in Argyll and Bute. Can you give us a flavour of what that means for pregnant women?

Jaki Lambert: The team with children and families is very much a multidisciplinary team. Earlier, we talked about perinatal health. There is short-termism in perinatal mental health, for example. Recruiting and training somebody into a role takes time, and the funding often relates to one specific person. That is not a sustainable model. Dawn MacDonald talked about a generalist model being required to upskill people so that people are not dependent on one individual. Such dependence is a fragile and non-sustainable way of providing a service.

Perinatal mental health is a really good example. The three years of funding ended before the regional roles were developed. Those regional roles would have provided the infrastructure to support the remote and rural boards, which would never have the capacity for the all-singing and all-dancing services. They often get left behind because people cannot be recruited easily and quickly to very specialist roles. You have to grow your own and take different approaches.

The multidisciplinary team for families in Argyll and Bute covers perinatal mental health and social work. It is about working with that team and health visiting around the family. That is a good model. However, it is quite isolated in the structure because it sits within an IJB. That can often create a bit of a challenge when people are trying to implement things that are directed through a health board.

Ruth Maguire: Thank you. That is helpful.

What solutions should we be considering to address the challenge of the scarcity of specialist staff? We have heard from previous panels about increased home visits and long travelling distances for staff members.

Michael Dickson is catching my eye.

Michael Dickson: We have two obvious opportunities. First, as the chief executive of the Scottish Ambulance Service, I know that we can deploy paramedics to take on home visits, for example. That releases the traditional primary care workforce to potentially focus on more acute patients who are coming through the door.

Secondly, the use of technology was referred to earlier. During Covid, we transformed very quickly to offering NHS Near Me appointments. Some of that has started to slip back. For patients in remote and rural locations who need to travel significant distances for a traditional short, 15-to-20 minute appointment, that can take up a whole day—if not longer, if the person is travelling from Shetland. Through letting go a traditional way of working, we can make better use of what we have.

10:00

We would all acknowledge that it is better to be in the room with a patient, particularly when difficult and bad news is being delivered. There can be working in a different way. Maybe a patient can travel to the local hospital, where there will be somebody who can support them during a conversation. However, that is not the normal way of working.

Ruth Maguire: Is that way of working happening anywhere?

Michael Dickson: Yes. There are some really good examples. Orkney and Shetland have very close working relationships with NHS Grampian. We have strong patient pathways for critical care, maternity and a number of other specialties. However, do we always think about people travelling long distances? That is not just in an island setting. Does the appointment need to happen face to face?

Nicola Gordon: We have heard about the broad range of skills that are required in remote and rural areas. Speaking on behalf of the nursing profession, what we hear from our members is that the work on a single medical ward can cover a range of services, from cardiac to Covid to paediatric services. The MDT model is therefore very much embedded in the way that working needs to be.

We think that there are opportunities to look at the development of the advanced nurse practitioner role. ANPs play a key role in delivering high-quality services in and out of hours in remote

and rural areas. Clinical decisions are taken closer to home and when patients need them, and we increasingly find that ANPs are being deployed to improve access to care in remote and rural settings.

We think that such things could be at the heart of the long-term strategies that are coming through. It is about looking at ways to expand and think creatively about MDTs. As I mentioned earlier, ensuring that nurses have the time and are funded and supported to undergo the significant amount of training that is required to become an advanced nurse practitioner is really important.

Some of those education and development aspects are being picked up through the nursing and midwifery task force, whose work has a number of components. Those are wellbeing, attraction, retention, education and development, and culture and leadership, which are all interlinked. A listening exercise is an element of that work. We want to hear what nurses and midwives say that they want in the future specifically for their own professions, but also in the MDT approach.

Jaki Lambert: Ruth Maguire asked whether innovation is already happening. If a midwife who works in a remote and rural area is looking after a baby who requires resuscitation, we have neonatal teams that will be there with them in the room virtually and will support them in providing that care. That model has worked really well for quite a long time, and it is streets ahead of many others in many ways in providing the ability to be beside a woman in her home while she attends a consultant appointment. We have been doing that for years. There is the blend of having somebody there as the woman’s advocate and the appointment still continuing. Connectivity is often an issue but, when that works, it works really well.

To pick up on Nicola Gordon’s point, from talking to midwives, there is a real need for recognition of advanced practice in midwifery. There is a willingness to take on things to ensure that that care can be provided, but currently that does not exist.

Nicola Gordon talked about the task force. I chair its education and development sub-group. We had a task force meeting last week. My concern is that the clearest message that comes across is that there is no money. That is very concerning in ensuring that we can take forward something tangible.

Ruth Maguire: Thank you. That is helpful.

Dawn MacDonald: Jaki Lambert is absolutely right: it is about the funding. We can make a wish list, but in an acute ward in a rural area, I could nurse a paediatric patient and then go to somebody with dementia and then to somebody in palliative care. We do that on a daily basis in small rural hospitals. That needs to be recognised. If it is not, people will go elsewhere, and we will not be able to retain staff. We absolutely need to recognise the skills that people need to work in remote and rural areas so that people feel valued in the job that they do.

Ruth Maguire: Thank you. That is helpful.

The Convener: Tess White has a supplementary question.

Tess White (North East Scotland) (Con): My question is for Jaki Lambert. Constituents in the north-east have shared with me that there is huge geographical disparity in the provision of specialist services, which means that many pregnant women and new mothers are not getting the help that they need. How could perinatal mental health services, for example, be improved as part of antenatal and postnatal care in remote and rural areas?

Jaki Lambert: Thank you for that question. I touched briefly on perinatal mental health services. The existing workforce requires education and development to be available, but access to regional support through models such as Near Me is key, and that was still not fully developed under the perinatal mental health plan.

We have to be realistic that we will never have every specialist service in every area, but there are ways to have access. That is about opportunities for development and a recognition that models may need to differ so that some generalist roles take on a broader remit. However, there must be some way of providing access to specialist services for the small number of times when they are required.

For some specialist services—for example, there are mother and baby units at three sites in Scotland—the expertise needs to be across the board; it is not available in every health board, which is still a gap.

David Torrance (Kirkcaldy) (SNP): Some of you have touched on workforce recruitment and retention issues already, and I have a question for Jaki Lambert. What particular challenges do nursing and midwifery staff who work in remote and rural areas face?

Jaki Lambert: I will describe a challenge. A student in the Western Isles was all the way through her training, and lecturers and colleagues very much told her to go and consolidate in a central area instead of taking up a post in the Western Isles. That person has never come back. There is a risk that people hear what are almost tropes that they have to consolidate in the central belt, which is not true.

A maternity care assistant or a support worker in maternity could be recruited 100 times over and

such people would often love to continue to become a midwife, but there is no access to that opportunity at the moment. Because those in the profession are predominantly female, they cannot leave their island or remote and rural area to access education. The nursing and midwifery task force is pushing for such access.

As Dawn MacDonald described, opportunities for development retain people. I live in a remote and rural area. I am talking to the committee online, which enables me to do my job. That option was not open to me previously, and it could enable someone to be a lecturer and an educationist. Such infrastructure roles are key to maintaining services, and they need to be recognised and valued.

We need to recognise that services are measured to the same standards. If something goes wrong, the same standards apply. The resource is needed to meet standards and to ensure that development and education continue. To make that possible, we need to make the most of the technology and abilities that we have.

David Torrance: My next question is to Michael Dickson; I am conscious of time. What are the additional challenges for ambulance and urgent care staff who work in areas where long distances between services are the norm?

Michael Dickson: What you are talking about is normal business for the Scottish Ambulance Service. During my first six months as chief executive, I have been fortunate to spend a lot of time with the crews, who love the job. They acknowledge that driving long distances or travelling in helicopters and planes is normal for the role—that comes with it.

The biggest challenge is that the routes that we used to use for recruiting technicians to move into a paramedic role—that gave people an opportunity to step up through the workforce and gain promotion and greater skills—now run through universities, so we do not have an earn-as-you-learn programme for technicians who aspire to become paramedics.

There is a kind of conveyor belt. We have call handlers who do the really difficult job of taking 999 calls and dispatching ambulances and who may aspire to become technicians. We can do the technician training, but then they may aspire to become paramedics. We are working closely with the Scottish Government to re-establish the tech-to-paramedic route.

The primary pressure comes from hospital handover times, but I suggest that we should not go into that discussion today. The main thing is that paramedics genuinely love the job. Local paramedics have a skill set that means that they can leave people at home. They can and often do work innovatively. They speak to consultants and to emergency departments to try to keep people at home when possible, rather than convey them to hospital.

The Convener: Nicola Gordon wants to respond briefly to David Torrance's previous question.

Nicola Gordon: I come back to the good question about recruitment and retention and I will pick up on points that have been made. We are hearing from members that pay structures do not always recognise the additional responsibility in remote and rural roles. In the NHS, a band 5 nurse can sometimes be the only registered nurse who is on shift. At band 5 pay level, she will be taking on the responsibilities that would normally be for more senior nurses—she might be covering the role of a senior charge nurse or a band 7 nurse. The pay structure does not reward that, which can be a disincentive.

Our members in rural and remote areas love the work and it is where they want to be, but we need to find a solution to provide career opportunities. Perhaps a different model would recognise the breadth of skills that are applied all the time.

On the question of attracting and retaining people, as has come up today, our members tell us that the perception of what work and life are like in a small island community—I am thinking of the example of Shetland—is different from the reality. Nursing in rural areas is not quiet and slow paced; it is just as stressful and hectic as elsewhere and can be more so, because people are very busy. People must be aware of the opportunities and what it is like to live and work in a remote and rural community.

To pick up on what Michael Dickson said, we must attract people and say that this is an excellent way of life—it is unusual and rewarding and people absolutely love it. The issue is how to get the balance right, how to provide opportunities for newly qualified nurses and how to make sure that student placements provide such opportunities, too.

Paul Sweeney (Glasgow) (Lab): When I attended a round table with student nurses a few months ago, a number of them said that, although they were keen to take up placements in remote and rural boards, they often could not do so as they could not secure accommodation and it was too costly for them to move. Does that ring true with the panel? How do we give students and qualified practitioners in a number of disciplines the tools to fulfil positions that they might want to take up in remote boards? I ask Jaki Lambert to start.

Jaki Lambert: You are absolutely right that the challenge comes back to accommodation, on

which I have seen innovation. In Argyll and Bute, we have no vacancies for midwives, because we have been innovative—I will use the past tense—in providing opportunities for development and for students to be employed straight into remote and rural areas.

The misconception was often held that people could not work in a remote and rural area unless they had consolidated for a couple of years in a central belt area. We have proved that that is not the case, but accommodation is consistently a challenge when people are undertaking their student experience and placements. We have worked with local caravan sites to get round some of the challenges. Accommodation is a challenge in taking up posts when people already have more experience and are earning more, and it is a big challenge at the beginning.

We do not have priority housing. For incentivisation, getting a home in an area makes people start to feel as if they belong, but it also opens the door to recruiting into areas. That is our biggest challenge.

10:15

Paul Sweeney: Mr Dickson, is the position similar for paramedics?

Michael Dickson: The position with paramedics is slightly different but comparable. Wherever we look in a remote and rural setting, accommodation is a primary challenge. I absolutely recognise the key worker issue. If we want people to live, work and stay in a local area, the ability to find and buy a house—housing supply—is critical.

I flag the HM Revenue and Customs component. If people are doing rotational work away from the central belt and they do a three-month or six-month placement in a remote and rural location, their housing is considered a benefit in kind. To be frank, I find it bizarre that they receive a tax bill for helping the people of Scotland, but that is genuinely the case for junior doctors who have placements in health boards. The problem is multifaceted; the point is spot on.

Paul Sweeney: Does Nicola Gordon have a perspective on the question?

Nicola Gordon: This is a particular challenge for nursing students. You will be aware that RCN Scotland surveyed students earlier this year; we had a high response rate, we held a round table and we published our report "Nursing Student Finance: The true costs of becoming a nurse". We found that nursing students across Scotland are facing significant financial pressures, which are partly linked to the cost of living crisis. We found that 66 per cent—two thirds—had considered dropping out of their courses because of financial concerns, and in 57 per cent of those cases, the reason was the cost of getting placements and of accommodation and transport for them.

There can be a particular challenge in remote and rural areas because of the distances that are involved and, sometimes, there is quite late notice. Some students tell us that they get about a week's notice that they need to go to one of the islands for their placement, so it is a bit of a scramble to get travel and accommodation sorted. We know that students have pulled out of clinical placements because they could not get accommodation.

Of the challenges, accommodation is probably the most critical to do something about, and it has come up a number of times today. There are also issues with clinical placement expenses, but we are making positive progress on looking at them with the Scottish Government.

Paul Sweeney: Do Dawn MacDonald's members feed back similar pressures for remote and rural placements?

Dawn MacDonald: Absolutely. When I worked in the community, we had student nurses who ended up giving up their placements because they could not pay for or get accommodation. Housing is a massive issue in remote and rural areas. When we supply houses, the feedback from students is about the rich knowledge and experience that they get in such areas, which they would not necessarily get in places such as Glasgow or Edinburgh. They value seeing a different skill set out there.

Paul Sweeney: You mentioned housing being provided. Can we look at examples that are a good model, relative to other areas?

Dawn MacDonald: One example is from what we did in Bute to keep student nurses coming there. We are a small island with a population of 7,000, and we wanted to keep the students coming. We spoke with some hoteliers and, because their properties are quiet in the winter, we did a deal with them to bring in students at a reasonable price. I cannot say that the accommodation was always fantastic, but I reiterate that, when placements happened, the students said their experience was invaluable.

Paul Sweeney: That is great. Do any other panellists have a view on pockets of good practice out there that we could home in on? Does anyone have suggestions for us to look at on accommodation provision or ways of promoting student placements that have worked well?

Jaki Lambert: In areas that still have protected accommodation, such as nurses residences, keeping a space that is always available for students has worked. This sounds ridiculous, but some members of staff have made rooms

available. I have seen that happen, which is maybe going a bit above and beyond.

Part of the challenge is getting arrangements in place with local bed and breakfasts. That trade is seasonal, which can often be a challenge. Some hospitals put up adverts to see whether folk can make rooms available. There has been some innovation, because people want students—they want folk to come and work in the area.

The approach often involves having local arrangements in place or protecting space. The challenge is that space has often been protected for medical staff but not for nursing and midwifery, and we have to fight the corner for nursing and midwifery.

Paul Sweeney: Thanks very much. If any thoughts spring to mind about places to look at, it would be great if you let us know by correspondence.

Gillian Mackay (Central Scotland) (Green): Good morning to the panel. To what extent is the right data available to ensure that the right services and staff are in the right places and that we are adapting staff to reflect the change in demographics, particularly with the ageing population and the increased number of people who are retiring to remote and rural locations? Dawn MacDonald is nodding, so I will pick on her.

Dawn MacDonald: There is data, but I do not know how good it is, which is an issue. How do we provide what is needed? We need to look at how we do that, because we know that people come to our geographical areas to retire. We have a lot of elderly people staying in the area. The problem is that we cannot recruit from a lot of the younger community, who we want to rely on for care at home. I do not profess to know how we address that, but you are absolutely right that we need to enhance and gather the data so that we can look at, reflect on and act on it.

Gillian Mackay: I do not know whether anyone else wants to respond.

The Convener: Jaki Lambert and Nicola Gordon both want to answer.

Jaki Lambert: One challenge with the data is that things such as Scottish index of multiple deprivation quintiles do not reflect well the populations that are in remote and rural areas. As we know, it is easier to define the SIMD quintile in the central belt. In remote and rural areas, somebody who is in poverty sits next door to somebody who is well off. Some of the data and reflecting the demographics is challenging.

We know that there are definitely a lot of retirees and a lot of people coming into areas, but we are still required to provide services—I keep coming back to that. If that does not happen, there is a self-fulfilling prophecy and people will not stay. Young people will not stay in an area if there are no opportunities for development or schooling and if there is no maternity service and so on. How do we stop what is happening? How do we go upstream, rather than just watch something happen?

Nicola Gordon: RCN's view is that the data that is used to inform workforce planning needs to improve. The data has significant gaps that need to be addressed, which can be a particular challenge for social care and general practice nursing.

We would find it helpful to have an accurate and transparent workforce baseline data set published ahead of implementation of the Health and Care (Staffing) (Scotland) Act 2019 in April next year, so that the measurement of improvement can be based on that and can be done as part of annual reporting. We would like workforce planning to be undertaken alongside, and integrated with, service planning. Service planning needs to be based on population need, rather than financial considerations and constraints, and on a commitment to creating and sustaining a skilled staff mix that reflects the community's needs. All of that needs to be based on robust data. There are challenges to that.

In addressing the challenges that are faced in rural areas, planning, budgeting and designing services are all linked, so having the data set to underpin work is important. Looking at where the gaps are and what can be done to address them is the key thing that we want the focus to be on.

Michael Dickson: I will be brief. We have a vast amount of data in NHS Scotland—it is astonishing—but we do not necessarily translate that into meaningful information so that good decisions are made.

To put the discussion in context, I note that it will take at least three years to adjust from whatever we have now. That is the time that it takes for a practitioner to move forward with their competency-based learning.

We have profound challenges in nursing and medicine. The Scottish Ambulance Service continues to recruit paramedics without significant difficulty—in fact, we could expand the paramedic workforce. If paramedics were used judiciously across the NHS in Scotland, they would augment services where we do not have the supply coming in.

Another factor is the attrition rates in universities, which vary across universities in Scotland. We as an organisation need to home in on that.

Gillian Mackay: In the interests of time, I will ask a quick-fire question; I hope that everybody will forgive me for putting them on the spot. We have spoken about housing and people acting up a band or two. What is your one ask of workforce planning—one key thing that would really help in your own disciplines in remote and rural areas?

Dawn MacDonald: Pay.

Michael Dickson: Let us look at supply.

Nicola Gordon: Sustainable long-term funding.

Jaki Lambert: As Nicola Gordon said, workforce planning must reflect population need and service provision—not case-load size. Sustainability is needed in relation to career options and progression.

Gillian Mackay: That is great.

The Convener: I call Ruth Maguire.

Ruth Maguire: Convener, I think that I have covered my questions.

The Convener: That is fine—thank you.

Ivan McKee: We have talked a bit about innovation. I want to focus on digital technology and other technologies. What should the national centre focus on in that regard? What are the barriers to bringing in new technologies? What support is needed to ensure successful implementation and roll-out? Perhaps Michael Dickson could go first.

Michael Dickson: Your first question was about the centre's perspective. Fundamentally, we still have independent health boards that are accountable to local communities for the delivery of service. I personally feel that the centre has a role to play in bringing those together—particularly when we see members of the workforce moving across organisational boundaries, as they do—and in demonstrating good practice and showing where that can be deployed effectively, rather than necessarily taking a leading role. I worry that if the centre took a leading role, we would start to duplicate other roles and responsibilities that currently exist.

Digital technology can be transformational if it is used effectively. In the work that we are doing with the Scottish Government and NHS 24, we talk about duplication and about stopping the patient having to repeat their story. Even leaving aside the distress that that causes for the individual, it wastes a huge amount of practitioners' time. Practitioners need to learn to trust the information that has been gathered by other healthcare practitioners.

The potential is there. We have a strong foundation—the fact that we have a single community health index number across NHS Scotland is massively powerful. We are only at the beginning of what that potential could look like.

10:30

Ivan McKee: Thank you. Does anyone else want to comment on that?

Jaki Lambert: Technology is essential for taking forward services, but so are the education, development and training that are needed to support that. It is not just a case of having the hardware; we need to ensure that we provide the best quality of care, that the people who attend for care and the people who provide care feel confident, that there are clear standards on what is expected, and that people have the right training and development—and the time to do it—to enable them to make the best use of that technology.

Dawn MacDonald: I have a couple of points to make. We struggle with technology when it comes to our members in catering and hotel services. They do not always have access to computers. We are moving to an entirely digital system, which I think is absolutely shocking when we have people who cannot access their pay and cannot do their annual leave because they cannot get access to a computer. In this day and age, if we are going to move to digital, we need to think about those people and we need to put in the training.

The bigger issue for me, from a nursing point of view, is care plans. We are still doing written care plans in people's houses. I am not saying that there is anything wrong with that, but the management information and dental accounting system was taken away because it was costing too much. Social work staff could get into MIDAS and see what we had done, as could AHPs and doctors. MIDAS meant that everybody had access and could wrap around that patient-centred care, but it had to be taken away because it was too expensive. If we are going to talk about digital, we need to make sure that we fund it.

Ivan McKee: When you say that it was taken away because it was too expensive, whose decision was that?

Dawn MacDonald: Local area managers.

Ivan McKee: That is very interesting. Nicola Gordon, would you like to come in on this issue?

Nicola Gordon: Yes, thank you. It is just a brief point. Michael Dickson made a really interesting point about trust and organisational boundaries. We need to remember that digital solutions underpin the services that are delivered by people. Ultimately, health and social care is about people providing services to other people. We need to remember that there are people at both ends of

the spectrum and that digital is an enabler for that to happen. That is worth bearing in mind.

I am conscious that one of the proposals that was discussed in the context of a national care service was the idea of a single national health and social care record. I do not know what stage that work has got to or how much is being done through co-design. I do not know to what extent that has been progressed or looked at. Ultimately, that is about having something that would be accessible right across the spectrum of health and social care services. Obviously, that is on the Scottish Government’s radar. I presume that, as those plans develop, we will hear more about that as the bill progresses through its stages.

Paul Sweeney: Do panel members have any examples of where digital interventions have worked well to improve access to healthcare in remote areas or in particular boards across Scotland that could be captured and scaled up to become a national standard? Does anyone have any immediate insights on that?

Michael Dickson: I apologise for the fact that I keep talking about Shetland, but it is a really amazing place. The lead consultant for diabetes worked closely to develop a portfolio of patients who might be deteriorating or considering going on to the pumps that monitor patients’ blood sugar levels. Instead of talking about a divide between acute and primary care, which is an artificial divide anyway, the consultant created a Teams channel so that they could review patients with the GP surgery and the community and district nurses. Because patients were continually monitored in that way, they did not need to go all the way—and it is a long way—to the Gilbert Bain hospital.

That meant that local reviews could take place, whereby the GP could work closely with the acute consultant to check whether there was any deterioration, which could be picked up early and adjustment made. The use of that digital technology meant that patients did not need to make that journey. It was a case of changing the way of working in order to empower the community teams that work with the patients more regularly, without losing sight of the fact that there was also an expert available who could provide them with help and support.

Paul Sweeney: That is a good example. Are there any other examples?

Jaki Lambert: There is one example that we have mentioned already—NHS Near Me meant that people did not have to travel two and a half to three hours down to Glasgow to see a consultant. That involved scanning services being provided locally but with remote oversight. We counted the carbon footprint of the miles of travelling that were saved. In addition, neonatal teams could act as another pair of eyes when you were caring for an ill baby. They could move the cameras and look at the baby so that you could provide hands-on care.

Such things are happening now and they work really effectively but, again, it is a question of resource and recognising that such interventions require skills and training and the infrastructure to support them. Much of this is about getting the central belt to buy in. The ideas and the willingness to innovate are already there in remote and rural areas.

Paul Sweeney: I turn to the central belt. GPs in Glasgow highlighted the fact that even if there are opportunities for technological improvement, they simply do not have the head space to even think about how such technologies could be deployed. Do you think that the staff you represent feel similarly constrained? Although the capability might exist, they are so focused on the immediate clinical demands of provision that they are not able to think about how to make that service improvement? What could be done to create the space to deploy new technologies?

Michael Dickson: That is particularly challenging. It is often easy to keep your head down and go on with what you have done before, because change would involve stopping what you are currently doing and switching to a new system, which is exhausting and time consuming. As you rightly said, people believe that they simply do not have the time to be able to do it. The use of targeted project management resource in the way that we did in Shetland, and as we have done in the Scottish Ambulance Service, can be really useful in enabling people to lift their heads up for a moment.

No one goes to work to do a bad job. If someone has always done something in a certain way, why would they consider stopping and changing to a different way of doing it? Project management support can help people through the change process and can help them to see what is possible and to see how they can stop doing what they are currently doing, let some stuff go and focus on new and innovative ways of working.

Dawn MacDonald: It is clear from listening to our members that we are struggling to provide basic care in the hospitals at the moment because of the recruitment and retention situation. For us, that is the most important thing—the bedside. We need to be there with the patient. We are struggling with the recruitment and retention of staff. You will know that the wards are short because we cannot get the staff to come in. We are using a lot of agency staff. If we say to staff who are nearly burned out, “Here’s something different,” they cannot get their heads into that space because they are too busy looking after patients at the bedside.

Paul Sweeney: So you would say that it is a bit of a vicious cycle.

Dawn MacDonald: Yes, it is.

Paul Sweeney: I want to pick up on the point that has been raised repeatedly about broadband being a physical constraint on access to a lot of critical services and capabilities. For example, I think that there is not a fixed-line broadband connection into certain geographies. Do you feel that the NHS should do more to provide satellite broadband services to all staff to give people the assurance of knowing that they can have access to the basic infrastructure that is required to carry out consultations or to access key services. Is that the sort of thing that might be worth looking at? Perhaps you could offer a perspective on that, Mr Dickson.

Michael Dickson: The NHS cannot be the solution for everything. Again, I am talking about Shetland here. We rely on mobile technology as well as broadband fixed-link technology. We worked closely with a particular community through its community hub. We helped members of that community to establish a suitable space where consultations could take place in a community hub, which avoided patients having to travel all the way down to the mainland hospital in Lerwick. There is a risk that we try to see that as the solution for everything, but we hope that the expansion of the rural mobile networks and the sharing that should take place as a result of that will give us greater opportunities.

To reference the national care service single patient record, we have a long way to go before we end up in that space. Mobile technology is great, but it has to work both offline and online and be able to reconnect and roll the records up.

Paul Sweeney: Jaki Lambert, would you like to come in?

Jaki Lambert: I agree that the NHS is not the answer to everything. Moving to an electronic way of working whereby every maternity record in Scotland is digital presents a challenge for midwives because there is no wi-fi. The issue is not just about the broadband connection. In small areas, there are very few people working in the NHS who can actually do the information technology—they are in very short supply. The infrastructure to support the IT needs to be developed because, with electronic records, there is no paper option. Electronic records are amazing—an obstetrician in Glasgow can be looking at the same record that someone in Islay is looking at—but we absolutely need to be able to connect from offline to online and so on. That is a real challenge, and if we do not have the infrastructure, that creates risk. We cannot get the move to electronic records right without the proper training and the proper infrastructure.

Public Health Scotland undertook a large survey of people who received maternity care and people who provided maternity care during Covid, and the biggest issue was training and development. If people are expected to move to new technology without having the appropriate infrastructure and training to do that, it often puts them off taking forward something that could be great. We need to have the right project management. The roll-out needs to be supported so that we can do remote monitoring, which works really well.

Paul Sweeney: Thank you. Nicola Gordon, would you like to comment?

Nicola Gordon: I agree with what Jaki Lambert said. The immediacy of the current workforce challenges makes it really difficult to free up people's time to enable them to undertake the training that they need to do. Yes, the infrastructure and the broadband connectivity are important, but there is also an issue about people being able to use those systems. In the NHS alone, we have around 5,500 nursing and midwifery vacancies, so the pressure is very much on providing front-line services. Therefore, the scope and the capacity to free up time for a number of the things that we have discussed today are simply not there at present. It is a case of dealing with the workforce challenges at the same time as trying to bring in some of the other solutions that would complement that.

Paul Sweeney: Thank you very much.

The Convener: I call Tess White.

Tess White: My question is for Michael Dickson. I just want to give you an example to highlight a profound challenge that we are facing right now. Over the weekend, as many as 17 ambulances were stationed outside Aberdeen royal infirmary's A and E department, which, as you know, serves both rural Grampian as well as urban areas. My question is: do you expect that situation to get worse over Christmas and new year? What actions could be taken to ease the pressure on the Scottish Ambulance Service both now and in the future?

Michael Dickson: I am profoundly concerned about the pictures that have emerged and, obviously, I am aware of the challenges that have arisen at Aberdeen royal infirmary and Dr Gray's hospital. I do not think anyone is trying to belittle the situation—I think that the challenge is a profound one, too.

Our bigger concern is that Aberdeenshire is, if you like, a single location, with no ability to call across as you would be able to do between Glasgow and Edinburgh. My other concern relates

to the rural communities surrounding Aberdeen in wider Aberdeenshire. We are working closely with NHS Grampian on how we can increase the number of call-before-you-convey approaches, which are about trying to stop people needing to be transported either to ARI or to Dr Gray's and helping them reach alternative models of care. We have an excellent integrated clinical hub and a flow navigation centre to get people to different locations.

However, the fact is—and this is a massive point of frustration for the crews caring for patients in the back of ambulances—those crews want to be out on the roads. Indeed, I mentioned this earlier. They want to pick up patients who are in dire need of help and care, but they are unable to do so, because they are parked often for hours outside an accident and emergency department. I have been out with these crews; I have spent hours in the back of an ambulance caring for patients; and I have seen the exemplary care that these people provide.

That said, even with the additional support of the hospital liaison officer—our member of staff who works closely with accident and emergency—we depend on that flow through. We have to recognise the profound number of delayed discharges that exist across the whole of the NHS in Scotland, and that 1,800 patients are currently sat in what are considered to be the wrong beds for their care needs. This is all about the flow through the system and all I can say is that we are working incredibly closely on the matter.

I do not think that things will suddenly and miraculously be transformed and that we will not have any more waits. We expect that there will always be demand on our service, so there will be delays—indeed, we are seeing that across Scotland—but the profound challenge that we are seeing at NHS Grampian is of significant concern to me, the rest of the board and each and every single crew member working hard across the Aberdeenshire area.

10:45

The Convener: Emma Harper has a supplementary.

Emma Harper: I have just a quick question. Outside of current issues, does the Scottish Ambulance Service have enough capacity to deal with remote and rural areas? We are talking not just about emergency transfers, but patient transfer to appointments, too. How would you respond to that? Is there enough capacity?

Michael Dickson: Over the past three years, we have significantly increased our ability to respond through the demand and capacity programme, and I am happy to share with the committee some information on how that has increased the number of paramedics and techs across the whole of Scotland. Through that approach, we have rebased our provision in a number of particularly remote and rural areas to extend provision in some centres from the previous 12 hours to 24 hours.

I think that we face two challenges. First, if we just continue to expand the Scottish Ambulance Service, all we will do is create more vehicles that will end up being parked outside the front of accident and emergency. We need to shift that from a system point of view to a greater focus on the back door and the flow through our acute hospitals if we are to enable that transfer. Because we based our demand and capacity modelling on a much shorter hospital turnaround time, the benefit that we are realising, although significant and despite the huge expansion, has been limited, simply because our hospital handover times have been greater than we had modelled—indeed, significantly greater in a number of areas.

We are in a much better place than we were, but the big focus must be on ensuring that we help patients get to the right place—in other words, the no-wrong-door principle—be that through NHS 24 or through the 999 system. People often dial the wrong number, through no fault of their own—after all, it is stressful if your relative is unwell—and we need to help them get to the right place using flow navigation centres and our integrated clinical hub. Yesterday, I was up in Inverness seeing the mental health—

The Convener: I am sorry, but we will have to move on. We have already run over time.

I call Ruth Maguire to ask about our final theme.

Ruth Maguire: Thank you, convener, and forgive my mind blank earlier. I did have another question to ask.

I suppose that this question will be for Dawn MacDonald and Nicola Gordon, but I want to ask about palliative care. What planning is happening or should be happening in that respect, given the changing demographic in our rural areas? You talked earlier about how communities are getting older, and I have previously asked witnesses about individuals having choice with regard to where they will be cared for.

Do you have any thoughts on that, Dawn?

Dawn MacDonald: Yes, absolutely. Because Marie Curie struggles in remote and rural areas, we provide the palliative care. We had a pilot in which community nurses were brought on to the night shift; after all, if people want to die at home, that is absolutely their choice and we should be able to provide that for them, but we should not be leaving them to die at night with nobody with them.

For me, that is just unethical, and we should not be doing it. Our pilot in that respect was a good one, but it was stopped, because of finances. If we are saying to people, “You have a choice—you can die at home, or you can die in the hospital”, we need the resources and the tools to enable that to happen with dignity and respect.

Ruth Maguire: I am aware of the time, but you just mentioned a pilot. A bit of a theme seems to be emerging of pilots and projects providing what should be core services, but instead they are being treated as extras. How do we get around that?

Dawn MacDonald: We need to stop it. The phrase that is used is “test of change”, but it is not a test of change. We need to get round the table and, as my colleague has said, get an understanding of what our communities need and what services they require. More important, we need the funding so that we can consult and speak to all our communities and promise them, “This is what you all want.” However, if we do not have the funding and the resources from the Government to provide that, there is no point in doing that work.

Ruth Maguire: Nicola, would you like to come in on that palliative care question?

Nicola Gordon: Just very briefly—I am also conscious of the time.

One of the things that has been touched on in today’s session is the breadth of skills that nurses demonstrate daily in their roles. A member to whom I was speaking recently highlighted neurological deterioration as a good example of where palliative and end-of-life care was being provided along with a range of other services. An observation that she made was the need for post-qualification education and training for nurses in remote and rural settings who are expected to provide that breadth of care. She said that neuro deterioration was a really important issue, as it can be all about very small changes. I think that it is something that we would like to look at.

We are aware that a bill on assisted dying for terminally ill adults will be introduced in the spring, and that is something that the RCN is starting to look at as part of the wider conversation about palliative and end-of-life care. We will be picking up some more work on that next year, and we will have more to say about it in the future. It is certainly something that we are very interested in looking more closely at.

Ruth Maguire: Thank you.

The Convener: I call Emma Harper.

Emma Harper: I have a quick question for Jaki Lambert about remote and rural midwifery practice. Because NHS Dumfries and Galloway stopped allowing babies to be delivered at Galloway community hospital in 2018, women are now having to travel 72 miles, and babies are being born at the side of the road. Indeed, Michael Dickson might want to pick up this question, too. I know that there are challenges with regard to education, competency skills and recruitment, and safety, too, is obviously a huge issue, so I would be interested to what Jaki Lambert has to say about the necessary requirements for skills, development and safety when it comes to delivering babies.

Jaki Lambert: When it comes to working in remote and rural areas—and I know where you are talking about—we need to recognise the skills that are required, to remunerate people and to offer that development. After all, you are very isolated in your practice. It is wonderful to work in a remote and rural practice, because you do use all your skills; however, there is no recognition of that. The fact is that, if you are trying to create a model without any consultant midwife or any advanced practice and if you are expecting everybody to do the same job and to be on call at a much higher level than many people would find acceptable, you are going to have a challenge recruiting to it.

It is absolutely right that people should be born in their communities, but it is also absolutely right that people should be paid appropriately, have their roles recognised and have enough of a workforce to ensure they are not putting on to what is a predominantly female workforce, with families et cetera, an on-call burden that is so unsustainable that they end up leaving the services, becoming health visitors or going into other jobs in, say, a family nurse partnership.

I do worry about the discussion around babies being born at the roadside as a result of mothers being transferred across Scotland from all different areas, because I am concerned about introducing an element of fear into these things. We have wonderful ambulance services and wonderful services that make it very safe for people to be transferred; after all, it is not suitable for all women to give birth in a remote and rural area. I am always very concerned about this narrative, because I do not want any woman to feel scared if she needs to be transferred for appropriate care.

The Convener: I call Paul Sweeney.

Paul Sweeney: Panellists might be familiar with the work of the University of Glasgow and Marie Curie on the dying in the margins project, which highlighted the reality of terminally ill people dying at home, particularly in poverty and with poor adaptations to their housing situations. What is your experience of how end-of-life needs and wishes are being addressed in rural settings? Are there particular challenges in supporting people in

those areas to have the death that they want, challenges that we might not see as much in urban areas, simply because those people do not have the same autonomy of decision making about staying at home in the final stages of life? Does anyone have a particular view on that?

Dawn MacDonald: If somebody has stated to us that they want to die at home, we will do everything that we can to make that happen. For example, we will put the green cross on the door to ensure that the ambulance crew knows that the person does not want to be resuscitated; they will have all their stuff and whatever else in there, too.

This is all about having a caring service; therefore, it is about not just the NHS, but social care, too. Those people need to be there, because we do not have or cannot get Marie Curie. The question is: how do we support that in the community and ensure that somebody is available? As I have said to Ruth Maguire, nobody wants anybody to die on their own, but how do we fund that? How do we train people up? How can the care services in the community support that?

Paul Sweeney: Are there any other perspectives on that?

Michael Dickson: I would just highlight the Scottish Ambulance Service's partnership with Macmillan Cancer Support to support people to die in their preferred location. I will happily share some information about that work afterwards, if that would be useful.

Paul Sweeney: Have you found, say, social housing providers to be co-operative when it comes to making adaptations to people's houses? Do you have any experience of people's homes in rural settings being adapted to support them in staying at home instead of their having to go into a hospice or an acute hospital?

Dawn MacDonald: Absolutely. In rural communities, occupational therapists and physiotherapists will come in, do assessments and work in multidisciplinary ways. Housing providers seem happy to help people stay in their homes and to adapt bathrooms or other areas as required.

Paul Sweeney: That was helpful. Thank you.

Jaki Lambert: I think that this is an issue where I would go wider. Where I live, it is very difficult to provide that level of care, because people could be living five miles up the glen. Again, it is all about looking at wider social determinants and ensuring that, when community hospitals are built, sheltered housing and other such housing are built around them, too, so that people can access the limited care provision that we have. They would be moving into housing that, sometimes, would be nearer to care facilities, which would allow them to access services when they chose rather than when they were in distress. Part of the challenge is that we have a limited workforce in the community and huge distances to cover, and some approach from a town planning perspective, which would not be for us to solve, would make a big difference in the long term, as we would be able to provide that care at home.

Paul Sweeney: Thank you very much for that. I appreciate it.

The Convener: I thank the witnesses for their attendance today. At next week's meeting, we will continue our inquiry into healthcare in remote and rural areas with a further panel of witnesses as well as taking evidence from the chief executive of the Scottish Football Association.

That concludes the public part of today's meeting.

10:58

Meeting continued in private until 11:57.

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