The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 17 March 2015

Session 4

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HEALTH AND SPORT COMMITTEE
9th Meeting 2015, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Mike MacKenzie (Highlands and Islands) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Dennis Robertson (Aberdeenshire West) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Peter Bennie (British Medical Association Scotland)
Professor Frank Dunn (Royal College of Physicians and Surgeons of Glasgow)
Ian Finlay (Scottish Government)
Kenryck Lloyd-Jones (Allied Health Professions Federation)
Sandra Melville (Royal Pharmaceutical Society in Scotland)
Liz Porterfield (Scottish Government)
Helen Richens (Royal College of Nursing Scotland)
Shona Robison (Cabinet Secretary for Health, Wellbeing and Sport)
Shirley Rogers (Scottish Government)
Harry Stevenson (Social Work Scotland)
Alison Taylor (Scottish Government)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 17 March 2015

[The Convener opened the meeting in private at 09:33]

10:11

Meeting continued in public.

Seven-day Services

The Convener (Duncan McNeil): Good morning and welcome to the ninth meeting in 2015 of the Health and Sport Committee. As usual I ask everyone to switch off their mobile phones as they can interfere with sound system. You will note—those of you who are with us for the first time—that members are using tablet devices instead of hard copies of our papers.

I start with an apology for the delay this morning. We had a private session to discuss one of the committee's reports.

I am pleased that we are here for this round-table discussion. Although I look round and see some familiar faces—old friends, nearly—as usual for a round-table discussion, I invite everyone to introduce themselves for the record.

I am the MSP for Greenock and Inverclyde and the convener of the committee.

Kenryck Lloyd-Jones (Allied Health Professions Federation): I am from the Chartered Society of Physiotherapy Scotland, and I am representing the Allied Health Professions Federation.

Bob Doris (Glasgow) (SNP): I am an MSP for Glasgow, and the deputy convener of the committee.

Sandra Melville (Royal Pharmaceutical Society in Scotland): I am a hospital pharmacist and a member of the Scottish pharmacy board of the Royal Pharmaceutical Society.

Mike MacKenzie (Highlands and Islands) (SNP): I am an MSP for the Highlands and Islands region.

Dennis Robertson (Aberdeenshire West) (SNP): Good morning. I am the MSP for Aberdeenshire West.

Harry Stevenson (Social Work Scotland): I am the president of Social Work Scotland.

Colin Keir (Edinburgh Western) (SNP): Good morning. I am the MSP for Edinburgh Western.

Professor Frank Dunn (Royal College of Physicians and Surgeons of Glasgow): Good morning. I am the president of the Royal College of Physicians and Surgeons of Glasgow.

Richard Lyle (Central Scotland) (SNP): Good morning. I am an MSP for the Central Scotland region.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I am an MSP for Mid Scotland and Fife.

Helen Richens (Royal College of Nursing Scotland): I am a policy officer at the Royal College of Nursing Scotland.

Rhoda Grant (Highlands and Islands) (Lab): I am an MSP for the Highlands and Islands.

Dr Peter Bennie (British Medical Association Scotland): I am the chairman of the British Medical Association Scotland. In my clinical job, I am a consultant psychiatrist in Paisley.

Nanette Milne (North East Scotland) (Con): I am an MSP for North East Scotland.

The Convener: Thank you all. At this point I usually ask a committee member to ask a question, but today I will get us going.

In its submission, the Royal College of Physicians and Surgeons of Glasgow

"urges the Scottish and UK Governments to remove the inequity of care at weekends and public holidays".

Does everyone agree that there is a lack of parity or an inequity of care at weekends and during public holidays?

Sandra Melville: Yes. I do.

The Convener: Does everyone agree?

Dr Bennie: I would say, "Yes, but". There will always be a degree of inequity between Monday-to-Friday working hours, weekends and the overnight period. In particular, when it comes to elective services, it seems to me that that should be the case, unless and until we have a hugely increased resource in terms of both money and not just doctors but all staff.

We see the focus as being about ensuring that we have good-quality urgent and emergency care right across the seven days of the week, whatever the time of day or night. However, we would not, at this point, be pitching to try to make the service at 3 in the morning on a Sunday exactly equal with the service during the week. My answer is therefore, "Yes, but".

Professor Dunn: I would largely agree with that. Our thrust, from the Royal College of Physicians and Surgeons of Glasgow, was to do with inequity of care for patients who are admitted urgently or as an emergency. We cannot have a situation in which someone who is admitted as an

emergency between Monday and Friday is more likely to have a chance of survival than someone who is admitted on a Saturday, Sunday or public holiday. The particularly vulnerable times are the holiday weekends that include the Monday. There is a huge build-up over the Saturday, Sunday and Monday because of a lack of the resources that are available Monday to Friday.

10:15

I agree that the elective situation has to be looked at differently. I do not think that our resources would allow seven-day working for everything. We must initially make sure that patients who are admitted for unscheduled care are treated the same and get the same standard of care, whether they are admitted during the working week or at the weekend.

Helen Richens: The Royal College of Nursing similarly believes that if a patient has clinically urgent healthcare needs they should be able to access high-quality care when and where they need it, irrespective of the time of day or the day of the week.

The issue is less about routine elective services being available and more about meeting urgent healthcare needs. Consideration of which services should be made available seven days a week should be evidence based. There should be proper analysis of what is best for patient outcomes as well as the best use of resources.

We have been talking about hospital services, but the issue does not arise just when patients are admitted to hospital. It is necessary to look across the whole system—hospital, community and social care services—and the whole multidisciplinary workforce behind that.

Harry Stevenson: In social care in Scotland there are some seven-day services that are provided 24 hours a day, but the level of consistency that you might want to find in terms of matching what people require is not there. Some personal care services are essential, and we need to ensure that they are provided at the right times.

The challenge will be in stepping forward together on the seven-day working agenda. In modernising the service so that the workforce is available in that way, there is work to be done on relationships with trade unions, for example, to ensure that we begin to gear up for the public.

Sandra Melville: I think that it is worth taking a minute to remember that the cohort of patients admitted at weekends is not the same as that of patients admitted between Monday and Friday. That is especially important when we are looking at where we should target our resources, which are finite, and where extra resources are required. The patients who come in at weekends tend to be sicker. They have not gone through the standard general practitioner referral system; they are emergency admissions and they tend to be frailer patients with comorbidities. They also tend to have more complex medicines and certainly pharmacists feel that we could have a valuable role in sorting out problems right at the start when a patient is admitted out of hours. We do that from Monday to Friday but not at the weekends, and I think that that is a definite gap in patient care.

Kenryck Lloyd-Jones: I agree absolutely that this is about unscheduled care. It is also about making sure that services are designed around the patient and in the best interests of patients, and looking for the evidence to support that. It is clear that more can be done.

The Convener: The reason why I opened with that question and want to press the witnesses on it is that there has been some debate—at least in the political sense—about whether the situation in Scotland is different in comparison with elsewhere and whether provision of seven-day services is a priority. I think that we all agree with the “but” expressed by Dr Bennie. However, are we also all agreed that there is an additional risk for patients who find themselves in an emergency situation on a public holiday, at the weekend or out of hours?

Dr Bennie: The research on that question tends to show that someone is more likely to die or suffer complications if they are admitted at the weekend, compared with those who are admitted between Monday and Friday. However, there are confounding variables, particularly regarding the differences between the cohorts of patients admitted at the weekend and during the week, as you have already heard. Those admitted at the weekend are generally more ill to start with.

It is straightforward to agree that we must ensure that we have good-quality care around the clock, but there are some uncertainties about the exact meaning of the research. Those who come in at the weekend are more unwell, so they may have worse outcomes at least partially because they were worse to start with rather than because we do not have the right services.

The Convener: Is it not the case that people who present at hospitals now are more unhealthy in general? That is one of the problems that our health service has: whether at the weekend or during the week, the people who arrive at hospital are more ill than used to be the case. They are kept in the community for longer and when they arrive at hospital they are vulnerable, they are older, and they have comorbidity—that applies generally, not just at weekends.

Dr Bennie: As far as we can understand from the research, people who come in at the weekend

are even more ill. Maybe the way to look at this is to be as sure as we can be about the evidence base. On page 2 of its interim report, the sustainability and seven-day services task force outlines the four areas that it is working on. They are:

"Define what we mean by seven day services";

"map current service levels across ... clinical areas";

"Define the requirements for seven day services";

and

"Identify the steps needed to ensure sustainable seven day services across NHSScotland."

We are very clear that that is the right way to go about things.

Our perspective at present is that the first part—defining seven-day services—has been delivered by the task force. The second part is, at best, only partially delivered, as we do not yet have a meaningful baseline of what is being provided at present. On the third part, we certainly do not have a clear definition of the requirements because we do not have the baseline.

The task force is doing good work but it is some distance away from being able to get down to the important part, which is to identify the steps needed to ensure that sustainable seven-day services are provided. I worry that you might push us to tell you what the answer to that is before we know for sure what current service levels are.

The Convener: We will get to the wider discussion of all the problems in a minute. All the written submissions identify many challenges and difficulties—that is not unusual when we talk about changing the health service; the committee is used to that. When I look at the issue, I know that it is going to be very difficult. If, as you have said, it is not clear whether there is a lack of parity at weekends and holidays or whether people are more at risk, why are we discussing seven-day working?

Professor Dunn: I think that there is some debate about whether patients who are admitted at the weekend are more ill, but there have been numerous studies—not just in the United Kingdom but in other parts of the world—that indicate that patients who are admitted at the weekend are vulnerable. That may be partly because they present at a different time, but I think that there are other factors.

When you look at the hospital at the weekend—at the support services within the hospital—and at the way that the community services are stretched as well, you can see a whole raft of problems. Patients being more ill is one trigger, but those of us who have worked in hospitals for many years appreciate that we work with much more of a skeleton staff at the weekends, and that has an impact on a number of different areas.

Kenryck Lloyd-Jones: The issue is not just about patient safety; it is also about things such as delayed discharge and the fact that there is enormous pressure on the system, which could be relieved if systems were more fully operational at weekends. That is why the issue is related to a much wider question of prevention and supported discharge.

Dr Simpson: Are we actually collecting the data? We in the Labour Party made a freedom of information request on workforces at weekends, and we published the response and were told that it was rubbish. That was information that was given to us by the health boards; we do not publish anything except what is given to us by the health boards.

Do we have data on the workforce during the weekend, as opposed to during the week? Do we have data about access to what the Royal College of Physicians and Surgeons of Glasgow have very helpfully listed as the tests that are required at the weekend? Are they available in every hospital that does admissions?

To refine this even further, I would like to ask about two more elements. We hear that weekend admissions are different to weekday admissions, but is there evidence that some people who are admitted to hospital at the weekend do not really require to be in hospital? I am told that the overall figure could be that as many as 30 per cent of people who are admitted to hospital do not absolutely need to be in hospital but could be managed elsewhere. Is the figure higher at the weekend, or are only complex cases admitted then?

The last question is whether the data on any specific condition show us anything. For example, we are supposed to admit stroke cases to a stroke unit within 24 hours, but that is not occurring as often as we would like. Are thrombolysis and tests for whether thrombolysis would be appropriate being done at weekends, or are they being delayed? Do we have hard data? That seems to me to be the starting point for determining whether we will make a perhaps quite significant change either in the distribution of the workforce initially, or in the total workforce in the long term, in order to cope with weekend working.

The Convener: Does anyone want to respond?

Helen Richens: I can comment on the data about the workforce. As part of its initial work, the task force did some baseline mapping of the services and the workforce that are available during the week, out of hours and at weekends. That initial step was certainly not enough to give meaningful data on nurses that could be worked

with; the way the data was collected produced very broad results on nursing numbers. From a nursing perspective, you need to know not just the number of nurses, but who they are and at what level they are working. The data that is held nationally and the data that was collected through the task force do not provide a robust data set that would allow that meaningful analysis. More could be done.

Professor Dunn: The situation with patients with heart attacks in Scotland gives us an example of what can be done. For patients in the west of Scotland, the Ambulance Service has now signed up, the technicians in the Golden Jubilee national hospital have signed up, the consultants work a 24-hour shift system and stay in the hospital at night, and the support staff do the same. Every patient who has a heart attack and needs to have a primary balloon procedure will have it within the specified time, irrespective of the time of day or day of the week when the attack takes place. That is because there has been a huge resource put into the system.

If we compare the position on heart attacks with that on other conditions, those aspects—such as support staff and availability of transport—are just not available in the same way for other conditions. For example, it is far more difficult to get transport home for patients who are discharged at the weekend and it is far more difficult to get a care package started for patients who are discharged over the weekend than it is for those who are discharged during the week. That is simply because people are stretched already and there is just not the resource to do it.

There is an issue at weekends. We have talked to the pharmacists and they can speak about the situation. There is certainly not the kind of infrastructure across the board that is seen in high-tech areas such as heart attack and stroke treatment. Of course, it is the frail elderly who need to have such infrastructure as much as anyone.

Sandra Melville: Professor Dunn has made some very good points. Some of those things could possibly be addressed by undertaking discharge planning and setting up care packages in advance. From the pharmacy point of view, preparation of discharge prescriptions can often be done in advance. What we are really saying is that we would like to see pharmacy at the front door when patients come in so that we could try to solve problems.

We are talking about whether the database shows that there are worse outcomes for patients at the weekends and, if so, why; the data quite clearly show that there are worse outcomes. There is a lot that we could do from the pharmacy perspective, not just in helping with discharge planning but in sorting medication issues out, as the patient comes in and throughout that patient's journey.

If a patient deteriorates, the medication that they are on becomes less appropriate. We have a big role in preventing avoidable harm for patients as well as in helping to facilitate their discharge by making sure that the medicines that they are taking are correct for them all the way through their journey, so that it is much easier to discharge them. That could be done with pharmacy technical staff overseen by a pharmacist. There is a lot that we can do to facilitate the patient's journey.

10:30

Dr Bennie: Sandra Melville makes a good case, but reading through the task force's interim report, it seems to me that the data are a bit piecemeal. We know a lot about some services in certain areas, but we do not know the availability of similar services elsewhere in the country. In order to make the right decisions, we have to have a broad baseline, because any decisions will ultimately be about prioritisation. We are simply not going to be able to provide all the services that everyone sitting at this table wants us to provide unless there are substantial changes in resourcing. Of course, anything that we provide at weekends within the current resourcing means a reduction during the week in the input of those same staff.

I realise that I am banging on about it a bit, but that is why I was hoping that the task force would soon have a much broader and more effective database of what is being done just now. Until we know that, we cannot map across: we cannot take, for instance, Frank Dunn's example of what happens in Glasgow and say for certain that that does or does not happen in Aberdeen or elsewhere in the country, or decide that it should happen in all parts of the country. If it should, where will the resource come from for it and what will we decide not to resource in order to achieve it? That is the core of the issue.

There is good work in the task force's interim report, but we expect the next report to be much broader, to tell us exactly what we have got just now, and to make recommendations on priority areas for improvement.

Harry Stevenson: The committee will see from Social Work Scotland's evidence that in areas that have tried to make available more services at weekends there is less discharge activity. Provision then becomes an overhead and the staff are not actually used, although availability exists. The situation is not consistent across the country, which is why we are all facing this challenge. I will make the same point again: unless we all move

this forward in step, with good anticipatory care plans, there will still be an issue about systems joining up well together. There are certainly challenges there, and although there is a willingness to identify where the issues might be, we would need to be discharging seven days a week.

The Convener: There seems to be a disconnect. Social Work Scotland's evidence mentions that some social work teams are available during weekends. The public might have an issue about when people are discharged. We see stories about people being discharged at 8 o'clock at night and people not being happy with their services, but there are some areas in which you went to the extent of sending letters to hospital wards to remind people that social services are available. I commend you for doing that, but is it all so disconnected that the local hospital does not know what local services might be available on a Friday afternoon, for instance? That is just as important as the Saturday or the Monday or the public holiday.

Harry Stevenson: I do not think that that is a criticism of the fact that folk are trying to make it happen, but it might raise questions about how well it was planned. Our evidence is that there is an issue about communication in very busy district general hospitals, and how the people on wards are made aware of what is available. That view can be a bit outdated when compared with what happens now.

The reshaping care for older people money gave partnerships lots of opportunities to try new things and to be innovative and creative. Some of that has worked very well but we still have a challenge around communication.

If you do not mind, convener, I will go back to the discharges issue. If we plan admissions well, there is a better chance of discharge being planned early and it should not be delayed any longer than necessary. There have been workforce issues in some areas and, at times, there are issues about resources. There is no doubt that those factors are being worked on. We need to get admissions correct.

One of the issues that I have picked up on, even in my own area—others might be able to comment on this—is about out-of-hours key decision-makers. Who are they? Do they feel confident? Are they risk averse, perhaps because they do not know about resources or because they are locums? That is not a criticism but an observation. Infrastructure issues might affect our ability to make sure that patients have a smooth journey.

Dr Simpson: Dr Bennie has made two very important points. We are having an almost theoretical discussion about changing the system to a 24/7 across-the-board even service, but it will take years to create the staffing level for that, unless there is redistribution from staff during the week. That seems to me to be fundamental.

We need to know whether there is evidence that if, for example, I have a heart attack in the west of Scotland, I will be treated in the Golden Jubilee hospital by a 24/7 gold-standard service that gives me the best chance of survival, but I will not get that in Aberdeen and Edinburgh. If that is the situation, it is a serious issue that we must address. The answer may be not to open up Aberdeen and Edinburgh services at the weekend, but to fly people to the Golden Jubilee hospital. We need to know whether the Golden Jubilee hospital's 24/7 service is fully utilised. There are different approaches.

We should be realistic and remember that we have the highest number of consultant vacancies ever and that we have a significant and quite rapidly growing number of nurse vacancies, with a reduction in the nursing student intake every year over seven years. That was done on a work-planning basis that may well have been appropriate—I do not know—but the fact remains that there will not be the staff to provide a 24/7 service that covers even the seven or eight areas that are listed in the interim report.

My question is really difficult. Do we need to move towards seven-day services? If we do, does that mean that Parliament needs to revisit targets on a collective cross-party basis? The system is currently target-driven from a management point of view; as long as we have to reach those targets from Monday to Friday, we will not—in my view—be able to extend services in the short term without major change.

The Convener: I was starting to get confused about whether you were giving evidence or asking a question.

Dr Simpson: Well, the question is—

The Convener: No—I got your point. The hard question is whether we need to move towards seven-day services. I was trying to get at that before. Is that a priority? Is there a drive to do it? Is there a risk? Where is the cost-benefit analysis? What will the outcomes be? How will we achieve them? I think that the other question was about distortion of targets. We will go round with those questions. I think that Sandra Melville wanted to come in earlier.

Sandra Melville: I will make two points, if I may. I would like to answer very quickly some of the things that Harry Stevenson said about discharge planning and getting it right from the start.

Maybe it is useful to consider some of the models of practice that currently exist. In the

hospital in Oban in which I work, we have the social worker every day at a board round, as opposed to a ward round. We all stand in the room together—everybody in the multidisciplinary team—and give a very quick summary of where each patient is with regard to their discharge and when their discharge is to be planned. We do that from Monday to Friday, but planning for the weekend is included. The social worker is there so that everybody is aware of the challenges that we need to overcome. Harry Stevenson used the C word—communication. Communication is crucial to the national health service, as it is in so many things. That approach could be rolled out wider to really help.

The more tricky areas that Richard Simpson brought up were very interesting. I do not think that we need an even service seven days a week, because we will not do all the elective stuff that we do from Monday to Friday seven days a week. However, we need a service that is as safe as possible for patients at the weekends, and I really do not think that we have that. It does not matter whether I think that; evidence suggests that outcomes for patients at weekends are not as good as they could be. They are worse than they could be, and I think that there is something that we could do. We should target resources where they would be most usefully used, because they are finite. The question is where we need to put in extra resource to make outcomes better for patients.

I admire Richard Simpson for bringing up the very tricky question whether we should be target driven. I do not know that it is for me to answer that question, but maybe being patient driven would be a better way to look at things.

Dr Bennie: I noticed, convener, that you were smilingly congratulating Richard Simpson on giving evidence. I agree with what he said. He asked whether we should be moving to seven-day services and whether we should reconsider the current targets. Our priority needs to be the quality of care that is provided to patients. There is no getting away from the fact that the current targets are about arbitrary measures—the four-hour wait in accident and emergency, for example, which as everyone around the table knows is driven by some of the things that we have already mentioned, such as the ability to discharge patients who are ready to go, which is a major area. Another target relates to waiting lists for elective surgery. It is easy to measure such targets, and we have got into a situation where, perhaps inadvertently, we seem to be prioritising elective surgery over urgent and emergency care. For me, that is not the top priority when looking at the quality of care that we provide, so I would like that to be revisited.

Kenryck Lloyd-Jones: We have covered the quality of data, but there are some fundamental changes required to the system. I am speaking on behalf of the allied health professions, which are not employed on a 52-week basis so, unlike for clinical staff, there is no backfill for annual leave or sickness absence. That needs to be addressed if we are considering the quality of patient care.

The second and more central issue is that if you simply spread services more thinly, you may actually provide a worse service, because unless things are co-ordinated you will end up with allied health professions in at weekends but unable to refer patients on to social services or to care in a community setting. We know that the Scottish Government has pointed out that there is virtually no community-setting AHP provision at weekends, with some notable exceptions. There are fundamental matters to address, as well as the quality of data and what we might prefer being considered.

Helen Richens: Some of the issues that Dr Simpson raised relate to the sustainability of the NHS as a whole. Over time, difficult decisions will have to be made about where we prioritise resources and where we can make changes that will have the best outcomes for patients, but we need to be careful because there are, at national level, so many areas of work happening and there are many different task forces. There are task forces for seven-day services, unscheduled care work, the out-of-hours review, and delayed discharge. We need to co-ordinate all that so that we can have long-term discussions about the sustainability of the NHS as a whole.

There is no getting away from the fact that, if we are to move towards seven-day services, it will cost. We need a proper evidence-based analysis of where changes to services have the best outcomes for patients and make best use of resources.

The convener asked whether we should move to seven-day services. I think that the answer to that is that it is about parity of outcomes for patients. If the evidence shows that patients do not get the same safe, effective, person-centred care at weekends or overnight, then we need to change how we deliver those services, but it needs to be part of wider discussions and it needs to be about sustainable services.

Professor Dunn: To reassure Richard Simpson, I focused on heart attack care in the west of Scotland, but it is a gold-plated service throughout the country. There are five centres, so people have access to those services wherever they are, although travel can be a bit difficult at times. That is an example of putting resource into a Scotland-wide service that has worked.

On unscheduled care, I totally agree that we need to address workforce issues. I know of physiotherapists who come in on a Sunday and do extra work and have to take the Monday off because of that. That danger of spreading the workforce has been mentioned, and workforce issues are important.

Helen Richens mentioned outcomes. We need to ask what the best outcome is for a patient: that may be a peaceful death in their own home with all the support that they need. We cannot necessarily measure outcomes in the way that we can measure four-hour waiting lists, but that does not make them any less important. It is a question of how we measure them, so that we can ensure that a patient is cared for in the right place and in the right way, and with the confidence of their family.

10:45

Bob Doris: This is a really interesting discussion. I want to refer to our witness Richard Simpson's comments earlier. [*Laughter*.] It was really interesting to hear about consultant vacancies and nursing student intake. Peter Bennie was talking about baselines—there is a current baseline of 1,200 more consultants than there were before and 2,300 more nurses and midwives than there were before.

I want to widen out the discussion. That is the context that Dr Simpson was talking about but it is about having the right workforce with the right skills in the right place at the right time. I do not want to get focused on consultants and nurses because the whole point, as we can see when we look around this table, is that it is also about the physiotherapists, social workers, occupational therapists and pharmacists—a whole gamut of people.

I am interested in knowing about wider workforce planning. Yes, we can have more nurses, but if the need is for a pharmacist to do a pharmaceutical care review at admission and to make sure that there is no delayed discharge because medication is not there at the right time, the best investment might be on pharmacists. It is about trying to make sure that we know correctly where the pressure points are. It goes back to the baseline argument. Some general comments on wider workforce planning would be good. I know that it is a complicated system but we also mentioned priorities—where would the priorities be?

Also, as a slight follow-up to that—is there buy-in from the various stakeholders who are here? For example, if I was a physiotherapist, like Kenryck Lloyd-Jones, and I had my physiotherapy clinics from Monday to Friday, and because of integrated health and social care, I was told, "We want to restructure so you will be in on a Saturday and Sunday now and you will have a seven-day contract, not a Monday-to-Friday contract," would I buy into that? Also, what are the financial consequences?

Likewise, for pharmacists and other professionals, is there buy-in to make this change, because it has to be done? Would restructuring contracts have financial consequences, irrespective of whether we increase head count? Where are the various stakeholders on that? Also, to go back to my original question, where would you prioritise?

Sandra Melville: Bob Doris has made some very good points, and I will add one more. We should not lose sight of the importance of working together—it was a common theme in a lot of the submissions. It is about the different skills that each of those professions can bring to the patient as part of a multidisciplinary team. Certainly on the consultant-led ward rounds that I go on every day from Monday to Friday, the feedback that I get is that they miss that service at the weekend. It is about working as part of a team and bringing in the pharmacy skill set, to the benefit of the patient. The same is the case with the physiotherapists and all the other team players. It is worth considering the situation in that context.

Harry Stevenson: There is already an infrastructure in Scotland in relation to health and social care and certainly social care services are required to be there; there are alert services for planned and unplanned events in people's lives because of vulnerability. In the case of Hairmyres hospital, which I deal with most in my job, we have a hub that involves OTs, physios, nurses and social work staff looking at the discharge arrangements, with care being a key part of that.

One of the issues for me is that we should not be assessing people in hospital beds. We need to get them home safely and then look at how their lives have been affected by the need for hospital admission. Evidence shows that some areas are trying to move forward with residential-type conditions of service. It costs more, but it is 24 hours a day. We need to develop that across the country to make it effective. However, I believe that the health and social care partnerships have an opportunity in their commissioning plans to begin to reshape services for the future and to make them available when they are actually required.

Dr Bennie: Bob Doris was asking about buy-in. Doctors are well used to providing a 24/7 service. We have done so certainly for as long as my career has been going and well before that. Provided that there is a clear need for medical input, that medical input will be there. Yes, there are resource implications—primarily about moving

people from Monday to Friday to the weekend—but the vast majority of doctors are working weekends already.

It is a good point about the integrated joint boards. It would be very helpful for them to have a stronger evidence base than the task force is able to provide at present so that they can run comparisons and be aware of what should be the baseline requirements. I worry that the boards will be working in a data vacuum and will run the risk of doing what we do a bit, which is to say, "We could do this," or "We could do that." In order to make sensible decisions, you must have a broad view of everything that is currently being done and make decisions on what are your priorities.

Helen Richens: Bob Doris's points about workforce are really important. We need long-term, integrated workforce planning that will support those important multidisciplinary teams. Although integration will help to do that, it was clear when we looked at the joint strategic commissioning plans for older people's services that, whereas partnerships recognised that integrated work planning was a priority, they were struggling to get the plans under way. More support and work is needed around that.

It is also about maximising the contribution of each profession in multidisciplinary working. Let us take the example of decision making. For patients to get the care that they need and for them to flow efficiently through the health and care system, we need skilled clinicians who are able and empowered to make decisions about people's care, whether that is diagnosis, treatments, referring for tests, admissions or discharge. Historically, clinical decision making has been seen as the role of doctors, whereas it is now more accepted that nurses or allied health professionals can also take on senior clinical decision-making roles. We have many fantastic examples of nurses, such as advanced nurse practitioners, working in those roles, often as part of multidisciplinary teams. We have lots of good intermediate care services, such as the hospital at home service in Lanarkshire, which is a completely multidisciplinary team of consultants, nurses, physiotherapists and pharmacists, linked with social care. Especially in a community setting, they are the ones who are preventing the patient from going into hospital in the first place and supporting them to be cared for at home.

We need to consider how those decision-making roles for other professions can support patient flow and seven-day care, and can support patients to get the best possible outcomes. However, we need to think about what is needed in the long term around sustainable workforce planning so that we have the workforce that we need to make those decisions and deliver those services.

Bob Doris: The more I hear of the evidence, the more I think that politicians—Dr Simpson and I, for example, do this a lot—set targets, such as 1,000 more nurses or 1,000 more doctors. We keep hearing about multidisciplinary teams. Do politicians need to be a bit more nuanced? Should we stop making headline commitments, in one clinical discipline or one allied health profession, to X amount of doctors, nurses, midwives or allied health professionals? Perhaps we should start asking, "What does the multidisciplinary team in this community need?" and resource that. It would make election manifestos a lot less exciting, but maybe they would be a lot more meaningful on the ground, when we start to deliver joined-up health and social care.

This is not a party-political question—my party does it as much as the Labour Party does—but can it be a bit of unhelpful when we pick one discipline, have these headline figures and go, "That's the target"? Does that sometimes miss the bigger picture of these multidisciplinary teams?

Harry Stevenson: I suppose that there might well be an infrastructure issue with particular disciplines. I am unable to comment on that. However, if we look at the infrastructure that is there already, and if we do this differently, do it well and focus on early intervention and prevention, there is a chance to have success through that.

When we discharge people from hospital admission, 50 per cent of those individuals will already be known to home care. That is the case in my local area. If we get someone in and support them through a six-week reablement programme with our home-care staff, we will reduce the need for home care by approximately 27 per cent.

There are quite startling bits of information at a local level, and everybody will have different bits of information about the impact in their area. Focusing on some of the issues that have been identified by the Information Services Division will help us to focus on those people who use, require and benefit from the most intensive services, such as pharmacy, medicine, nursing and social care. We will know those individuals—they do not make up a large number in Scotland—and we could focus on how well we support them.

We now support many more people to end their life in their own home, as was mentioned earlier. The skill that is required for that is huge for social care staff as well as for those in other disciplines in the health and social care sector.

We need to recognise that there are a lot of good things going on as well as significant challenges. The vehicle is health and social care

integration. The direction of travel, and the support and leadership that will be required to make those changes, will be very important for the next five or 10 years.

Professor Dunn: I was delighted to hear what Bob Doris said, because I think that the general public—and indeed allied health professionals—are bewildered by the information that comes from different political parties to score points. For example, a party may say that there will be 700 more consultants, but the percentage of vacancies is 7.5 per cent, so what does that mean?

I agree that it is far more important to look at systems, which involves looking at the whole panoply of allied health professionals. It would be far more valuable for the public and the allied health professional groups to hear that we have a system in place—which might involve the example imported from Lanarkshire—that will allow elderly patients to get into their own homes at the weekend as well as during the week. We can make that contribution and then look at the next contribution.

Although that approach may seem piecemeal, I believe that all the small cogs are very important. We have seen in Lanarkshire and in other places the examples of excellence on which we need to build. The public would really like to hear that there is a combined operation that leads to a clear end point—for example, the right location for an elderly relative.

Kenryck Lloyd-Jones: On the question of buy-in, the allied health professionals and professional bodies absolutely support the ambition that people should see an allied health professional when they need to. That is an ambition for all of them.

However, the question that Bob Doris raised is really about integrated planning. When we refer to people, we ask whether someone is an AHP or a nurse, but even the term "AHP" is difficult, as there is not a single AHP. The term covers a range of professions. The question that we have to ask is not how many AHPs we need but how many speech and language therapists, occupational therapists, radiographers and so on we need.

That is why the issue of leadership is essential in considering the whole issue. The decision-making process by which services are planned needs to be inclusive, and needs to involve the strategic input of the allied health professions—the nurses, pharmacists and medics—to ensure that we are operating optimally. Otherwise, the danger is that we get physiotherapists or OTs in on a Saturday but they are not there on a Monday, which simply provides a worse service because, even though there would be allied health professional provision on a Saturday, there would be no interlinked services to refer people on to. There would therefore be a reduced service at the weekends, and yet those staff would not be available during the week.

Dr Bennie: I back up the evidence from the other witnesses. Bob Doris seems to be asking us what we would like politicians not to do.

Bob Doris: Could you keep the list short, please? [*Laughter*.]

11:00

Dr Bennie: Actually, there is only one thing on my list. Reading through the report of the task force, it seems to me that it is not yet at the stage of starting to make recommendations, but it is reporting on the number of units that do acute surgery across Scotland, and more than hinting that, in terms of providing good-quality care, there are probably too many. I would quite like politicians not to campaign to keep a hospital open if the conclusion of the task force's work is that the best way of providing good-quality care is to move some of those resources into the community and to reduce the number of acute units in order to ensure that the quality of care for patients and the outcomes for them improves. I probably do not need to go over the track record on that kind of issue, other than to say the words "Kerr report".

Rhoda Grant: Setting aside the staffing issues, which we have covered, there are surely advantages in moving to seven-day care. For example, all elective surgery is done from Monday to Friday, but the pattern of most people's lives lends itself to having elective surgery at the weekend because of childcare and work commitments. If someone was having day-case surgery, it would be much easier for them to go in on a Saturday and get it done, and they would be back at their desk, or they could get family to help out with childcare.

That obviously has staffing implications, but would it not allow hospitals to be staffed cost effectively to deal with emergencies at the weekend?

Professor Dunn: There is a point here. On the one hand, the reason why the hospitals are more resourced during the week is that there is a lot of elective activity, and unscheduled care patients benefit from that. However, the view of many health professionals is that moving to elective surgery at the weekend is a step too far at present. Again, we have the health professionals to think about too. Are they going to want to come in, or have the resource to come in, every weekend for elective activity, given all their family pressures and so on?

The drive here is to ensure that we do the very best we can to ensure that unscheduled care

patients have an even service over seven days. Many of us feel that the focus on elective surgery should come at a later stage, depending on resource and everything else. I certainly think that in Scotland, especially given the conversations that we have had south of the border, it would be a huge step to move to a seven-day elective service. That would, in my view, be beyond us at present.

Rhoda Grant: I was trying to make the point that, although such a change would of course have staffing implications, it might, looking to the future, be desirable, Given that you would have to increase staffing and training and the like, you could not do it tomorrow.

Professor Dunn: I would love the unscheduled care service to be even. Once we have done that, we might have a platform to allow us to look at the next step. That would be such a major challenge for us, and the whole issue of unscheduled care dominates what we are doing at present. Elective activity is very important, for patients' quality of life and everything else, but we have such a huge issue now with the frail elderly population that embraces primary care and community and hospital work. We are all in this together, and that is why some aspects of the training of young doctors have changed to ensure that we embrace their skills both in the community and in a hospital environment.

The Convener: That does not necessarily mean that we cannot move to what Peter Bennie suggested with regard to care and focusing on certain units—such as Clydebank, going back to our discussion about heart attacks earlier. It does not necessarily mean that the professionals would work any more weekends than they do currently or than they have in the past. If they were based in a particular area of activity, they might be working only one in 20 or 30 weekends, if there was a sufficient team to carry them.

Dr Bennie: The key point to get across is that the NHS in Scotland is very stretched at present, and we have to keep the focus on ensuring that we have a sustainable and working NHS moving forward into the future. Urgent and emergency care is at its heart and is essential. It is what the health service is there for, whereas I think that elective care at weekends is primarily about convenience. We have to ensure that the health service is fully effective at doing what it has to do before we start trying to improve the other aspects of it.

The Convener: But if they were there, it would not be in the interests of the national health service to have them underutilised at weekends, with consultants and surgeons waiting around for somebody to come through the door.

Dr Bennie: That is my point. I am not aware that there are any major issues with underutilisation of NHS staff. It is quite the opposite. The vacancy rate for doctors and the number of extra hours that doctors are working unpaid show that we are not in a situation where we have people twiddling their thumbs, and it is likely that we are not providing as good care as we should be in urgent and emergency services. Surely that has to be our focus just now.

The Convener: We will have a chance to speak to the new cabinet secretary later. The previous one, Alex Neil, said:

> "Since we are paying them anyway, very often triple time, to be on call it would be a far better use of their talent and resources to have them working and, for example, discharging patients who are ready to be discharged."

He seemed to recognise that we are not using doctors effectively and in a sustainable way. I cannot provoke Peter Bennie to respond, can I?

Dr Bennie: You can probably see the various responses that I might make to that. Perhaps the first is to point out that doctors and consultants who are doing urgent and emergency care are not paid triple time to do that. They are paid time and a third. The previous cabinet secretary simply got that wrong.

People are not twiddling their thumbs. The health service is extremely stretched already. We are talking about trying to ensure that it provides the best possible care for those in urgent and emergency situations, and there has been a baseline acceptance in the task force that that is the focus. It is a distraction to start talking about elective surgery on Saturdays and Sundays when the risk is that we are not providing good enough care in the urgent and emergency setting.

Rhoda Grant: My point was that, if we did elective surgery at the weekend, we would provide better care in the emergency setting, because we would have the professionals—the radiographers, doctors, nurses and other staff—in to do that work and they could then be diverted to deal with emergencies. It seems from the response to the freedom of information request that we made that staffing at the weekend and staffing during the week are like chalk and cheese. It is almost incredible that staff can deal with emergencies, given the numbers that are rostered on. If you had people on, they could deal with the emergencies.

Sandra Melville: I have a comment on the use of existing resources. I do not know whether anybody here saw the item on the BBC news this morning about NHS England using pharmacists in the community within a whole-system approach. I am sure that nobody round the table will be surprised to hear that we are way ahead of that in

Scotland. We have had that system in place for many years.

Community pharmacists work closely with GPs and provide the minor ailment service that the Scottish Government put in place a while ago. Through that service, pharmacists deal with a lot of patients who have minor ailments. They prevent those people from troubling GPs, and they are available at the weekend. Community pharmacies are open every Saturday and a lot of them are open on Sundays. That resource is already there.

Pharmacists also prevent admissions to A and E. Patients will rock up to A and E because they cannot get to their GP's surgery and they think that it is far easier than phoning NHS 24. They think, "What's that phone number again? I'm not sure."

At present, 890,000 patients in Scotland are registered with the minor ailment service. They are the only ones who are eligible for it, because they were previously eligible for free prescriptions. Some 80 per cent of the population of Scotland are not registered. If we extended the service to everybody, we could make a huge difference by taking the pressure off. As Peter Bennie rightly said, NHS staff in hospitals are not sitting twiddling their thumbs—quite the reverse. Extending that service could help to alleviate some of the pressure that arises from people coming through hospital doors out of hours.

Kenryck Lloyd-Jones: I think that the issue that everybody is struggling with is the prospect that, if we move from a five-day service to a seven-day service, there will be an extra two days on top of the five days, which is a 40 per cent increase, and we are going to achieve that either through a 40 per cent increase in funding or by thinning services out during the week. I do not know whether there is any evidence that it would be better to thin services out completely evenly. There is a fear that it would not be most efficient to have everybody go home at 3 o'clock so that they could be at work on Saturdays as well.

The other question is whether, if the resource were to be increased, it would be best devoted to acute care for elective surgery at weekends when the money could be spent in many other ways to reduce pressure on A and E, to introduce preventative measures and to support discharge into the community. Surely the extra funding ought to be devoted to those areas rather than to stretching services more thinly to cope.

Harry Stevenson: This is just an observation. We seem to be focusing very much on acute hospitals although, if we were to get more capacity, more services and more flexibility in health and social care in the community, that would make a difference to what happens in hospital wards and how we get people back out again.

The Convener: You are right that we are focusing on acute hospitals, whereas your submission—we thank you for it—has a much broader focus. Local pharmacies are open on Saturdays and there are phone numbers to deal with care workers and social work services at the weekend. That is still lacking to a degree in the acute sector or it is not as apparent. Indeed, at weekends and during holidays—including recently the long weekend over Christmas—there does not seem to be the degree of flexibility in the acute sector that there is in some other sectors, such as the primary sector. It is natural that we skew a bit towards the acute sector, because the flexibilities in other sectors—whether or not we are where we want to be with them—are obvious, whereas they are not as evident in the acute sector. I see Peter Bennie grimacing at that.

Dr Bennie: Convener, I think that you are in danger of paraphrasing slightly beyond the reality. At present, the acute sector provides very little elective surgery at the weekend—not nothing at all, but very little compared with during the week. However, in emergency and urgent work, every hospital in Scotland is working flat out every weekend and every night to care for patients who come in with severe illnesses. We are looking at how we can improve that situation, not at how we can start an emergency service at weekends. We have a fully functioning emergency service at weekends; we are just looking at how we can improve it.

The Convener: In comparison with what is already happening in other sectors.

Dr Bennie: No—absolutely not.

The Convener: Do you not agree that there are some good examples—from social work, pharmacies and other services—that your profession could learn from?

Dr Bennie: Let me try to answer that. It seems that you are trying to box me into a corner.

The Convener: No—I am not boxing you into a corner at all. I am asking you to recognise what is staring us in the face.

Dr Bennie: You might have noticed me nodding when colleagues gave evidence about the need to continue to beef up our community services. I am saying that there is a danger of drifting into a mindset that says that it is only in the community that there are flexibilities and that people are working outside what are for most other people normal working hours. In fact, the developments in the community are relatively recent in comparison with the acute, urgent care that hospitals have been providing right through—and hospitals are

continuing to improve what they do. I am a little wary of our concluding that the current service does not work.

11:15

The Convener: I think that you are being overly defensive, but we will leave it at that. I am asking you to recognise that, in the community, there are some very good practices that the acute sector could possibly learn from.

Dr Bennie: And I have—

The Convener: If you are saying that you have nothing to learn and you are ahead of that—

Dr Bennie: There is no way that I am saying that. It is outrageous to suggest that I am saying that there is nothing to learn. I did not say that.

The Convener: Do you accept that there is some good practice in the other sectors that you could learn from?

Dr Bennie: I would go much further than that.

The Convener: Good.

Dr Bennie: I agree that there are excellent practices outside hospitals and in hospitals. I am not in any way suggesting that there is nothing in the community to learn from.

The Convener: But we all need to make progress.

Dr Bennie: Yes.

The Convener: Good. Let us make progress then.

Helen Richens: When we start talking about "acute" and "community", there is a risk that we separate them out, rather than thinking about the flow of patients from the community, into hospital and out again. We need to look at the system as a whole and consider how community and acute services impact on each other whenever we have any of these conversations. My plea is that, although community services are very important when we consider the seven-day services agenda—and we have heard examples of really good community services—we need to consider the system as a whole and understand how different areas of it impact on each other.

Mike MacKenzie: I should probably draw the committee's attention to the fact that Sandra Melville is my sister-in-law. I hold her in affection and respect her professional abilities, but that is not why I was struck by the submission from the Royal Pharmaceutical Society, which seemed to offer possibilities of low-hanging fruit. She has outlined how the minor ailment service could be extended, but it strikes me that there are other opportunities—other low-hanging fruit to be picked. To go back to the submission, the Glasgow pilot scheme suggested that there is low-hanging fruit to improve clinical outcomes. Can the other witnesses tell us where there might be other low-hanging fruit that could be picked before we have a full-blown review?

If I were to attempt to convince John Swinney that there is low-hanging fruit in preventative spend, I might say, "Mr Swinney, you could spend £10 here and save £20." If we bear in mind the context of austerity, how would you make the case to him for preventative spend? Can you put some numbers on that?

The Convener: Kenryck Lloyd-Jones is going to put some numbers on that.

Kenryck Lloyd-Jones: I will take the point about preventative spend first. The Chartered Society of Physiotherapy has just produced a falls prevention economic model. When we look at the cost of the impact on older people of falls—not just because some of them are serious and lead to expensive hip replacement surgery but because of the cost of rehabilitation and social care—it is clear that falls prevention is a bit of a no-brainer. We have put figures on that for every health board area in Scotland, and I can see members later and offer more details on that. Addressing that would require investment in preventative services.

We were speaking more generally about acute versus community services, and I agree with Helen Richens that we must go with patient flow. We must bear it in mind that the Government paper that went to the task force said that the provision of seven-day services is almost non-existent in the community setting for AHPs, with some notable exceptions. There are some fantastic notable exceptions, but they remain exceptions.

The potential to improve patient flow is tremendous, but it requires investment in things that are similar to the example of the home hospital services in North Lanarkshire, where multidisciplinary teams provide care outside hospital, which prevents the need for acute care.

Acute care is very expensive, and anything that we can do to reduce the demand on acute care and to get people out of acute care more swiftly is to the entire NHS's benefit. It is not just a question of acute versus community.

Sandra Melville: I thank Mike MacKenzie for bringing up the submission from the Royal Pharmaceutical Society. He made a good point about low-hanging fruit. The pilot that took place in Glasgow royal infirmary—it was only a one-month pilot—clearly showed that, when clinical pharmacy services were provided at the weekend, there were improved patient outcomes.

The submission contains the statistics concerning the drug therapy problems that were identified, such as omitted doses and adjustments that needed to be made because of patients' deteriorating clinical conditions. Those outcomes are easy to achieve simply by providing the clinical pharmacy service, as has been demonstrated not just in Glasgow but in various pilots throughout the country.

A recurring theme is that in order for the provision to be sustainable and equitable across the patch—as many of my colleagues have said—we cannot stretch what we have through the week too thinly; it needs to be resourced. I think that John Swinney would be receptive to that.

Helen Richens: I can give an example of low-hanging fruit. I mentioned advanced nurse practitioners earlier. Nurses in such roles have clinical skills and decision-making capability, and they work in a range of settings—in the community, in acute care, sometimes attached with GPs and sometimes as specialist nurses in the community and mental health services. There are fantastic examples of how advanced nurse practitioners can improve outcomes for patients and can keep people's treatment in the community, so that people do not go into hospital.

In NHS Tayside, there are specialist heart failure nurses who manage patients in the community. They follow the Scottish intercollegiate guidelines network guidelines so that patients do not have to go to their GPs but can be managed in the nurse-led service. NHS Tayside has achieved good savings by avoiding admissions to hospital.

However, the provision of advanced nurse practitioners and nurse specialists is patchy across the country. More national co-ordination and longer-term workforce planning are needed to create a sustainable workforce of those roles that can support wider multidisciplinary teams.

Dr Bennie: I support both those examples. Sandra Melville has spoken a few times about the potential value of having pharmacists available on ward rounds at the weekend. There is a very good case for that and I agree with it.

Having said that, I am slightly wary of the low-hanging fruit question. It often comes up and it always feels to me that there is a danger that it involves short-term thinking. The subject that we are discussing is so broad that we have to get it right. Each of the low-hanging fruit that we have heard about so far would cost money and would involve a decision being made about resources that would restrict the other available resource.

Whether we should think short term or long term is a difficult question and it relates to the question about where the most value for money is. I think that the most value for money is likely to be in primary prevention of ill health by reducing smoking, reducing drinking, improving people's diet and balancing up as much as possible the social inequities in Scotland.

It is a widely known statistic that life expectancy is 15 or more years better in the leafy suburbs of Bearsden than it is just a few miles away in the east end of Glasgow. Dealing with that issue is where the spending of money makes the biggest difference. However, it does not do so on the timescales of low-hanging fruit. That requires a real commitment to improving the overall health of the people of Scotland and reducing the demand on health services.

Harry Stevenson: I will make a similar point that relates to things that the committee already knows about—health inequalities and their impact on people's lives, the ageing population, poorer health in ageing and the challenges of all that. If the intention is that the integration boards will have in scope elements of unscheduled care, and if we are to make a transfer from emergency and acute services to those that are based on a preventative approach, we need to shift resource. Bridging that is part of the challenge. There is an opportunity to do that with the integration fund. I am optimistic about that, because I think that it can work. That is one of the mechanisms that we should use to make the shift take place.

We need to consider how we blend in new investment, if it is required, over and above the things that we currently do. We must also consider what we need to do differently to redesign services. All that lies within the scope of the new integrated bodies.

Mike MacKenzie: I thank Kenryck Lloyd-Jones for his answer. I have not read the report that he mentioned, so I hope that he will share it with the committee, but it seems to provide an example of what I was looking for.

Perhaps I should have articulated my point a wee bit better. Maybe "low-hanging fruit" was not the best description, but there seems to be a case for doing some rather obvious things now. I want to get beyond the anecdotal evidence and pilot studies. Can any of the witnesses guide us to a health economist who has published work on the matters that we have been discussing, so that we can take decisions on the basis of something that is beyond the anecdotal?

The Convener: I will add a question that the committee has asked before: what will we stop doing to allow us to do better things? Maybe that is the wrong question to ask at this stage, with the cabinet secretary hovering outside—she is on our next panel—but I will throw it out there anyway, along with Mike MacKenzie's important question.

Professor Dunn: I wanted to make the point earlier that, yesterday, I spoke to staff at Glasgow royal infirmary in advance of today's meeting. It was interesting to hear from one of the consultants in unscheduled care—an acute medicine consultant. Five consultant physicians are on duty every Saturday and Sunday at the royal infirmary. By the time they have dealt with the acute patients, it is probably early afternoon, and then they go to the so-called downstream wards. Some patients might be in the wrong ward—they might be in a surgical ward because no beds are available in a medical ward. Other patients will have got over an acute incident and will perhaps be ready to go home. While the junior medics are waiting for the consultant, they do not feel in a position to decide about discharge. If the consultant is busy, it will be late in the day by the time they make the decision, so there will be difficulties in getting transport. Even if transport is arranged, it will not be possible to arrange the appropriate care package for the patient.

From the medical staff right through the system, there are areas where more support is needed. We cannot focus on one aspect and say that it is working well but the rest is not. All aspects are working to their capacity, but every segment needs to be improved to help with the process. It might seem that getting patients home does not affect the outcome for them, but of course it does. If we can get a patient home as soon as is safely possible, that is the best outcome for them, and that applies more the older the patient is.

The Convener: If there are no other responses to Mike MacKenzie, we will move on.

Nanette Milne: The discussion has been fascinating and wide ranging. It is clear that a lot of work is being done and that a great deal needs to be done. One group of health professionals that has been mentioned only in passing is the GPs. During the passage of the legislation on adult health and social care integration, I made clear, as did other members, the importance of the GP in a leadership role, particularly in local integration boards. I hope that we have not deliberately sidelined GPs this morning, as they have a key role.

I am married to a retired GP of the era when doctors went into their surgeries on a Saturday and a Sunday. At that time, we never dreamed of completely closing surgery premises for the whole weekend. I would make myself unpopular with the modern GP were I to suggest that they should go back to working on Saturday mornings and even on Sundays to see their patients. What would be the comments around the table on that?

I accept absolutely that nurses and other health professionals have a huge role, but the GP plays an integral role—even an overarching one. At the risk of making myself unpopular with some of my younger medical colleagues, I suggest that part of that role could well be at weekends.

11:30

The Convener: I wonder how popular Nanette Milne will be with that suggestion.

Dr Bennie: I thank Nanette Milne for bringing up GPs. It is late on in the day to do that—technically, it is after the session was due to finish.

First, what Nanette Milne says about the importance of GPs having a leadership role on the integration joint board is true. We do not have any grave concerns about GPs not doing that—the places are there and we expect that they will take them up. However, general practice is stretched, so GPs may face difficulties in getting to meetings, especially if they are called at short notice.

There is also a place on the IJBs for secondary care doctors to play a leadership role. That is crucial. The BMA has had little difficulty persuading GPs of the need to be on board with the agenda. It is a bit more of a challenge for us to get colleagues in secondary care to be fully aware of the changes that are coming and how those will affect hospital practice, as well as general practice.

Nanette Milne asked about GPs working at the weekend. Like all other doctors, GPs provide a medical service 24/7. They do not provide the service to their patients as they used to, but I would hope that most people around the table understand that that is because the previous model was untenable. It is much more sensible to provide more centralised services at weekends and at nights. The Scottish Government is doing a whole separate strand of work on out-of-hours GPs services, with a report due later this year.

Sandra Melville: I am aware of the time, so I will be brief. The interim task force report mentioned a model of care in Fort William in which the GPs are very much involved. The task force mentioned the challenges in remote and rural areas, which we have not had time to touch on. The Fort William solution is a good one—they have the GPs in the hospital and use their skill set in an integrated way in the acute setting. Perhaps that approach could be explored, too.

Kenryck Lloyd-Jones: You asked about what we could do or stop doing, convener. An essential factor for the whole system is that we must incentivise prevention better than we do at present. With the current funding models, even over a two or three-year period, we may not get back the money from the investment that we put into a preventative care scenario. Indeed, we might not get back the money for five or ten years.

Although the money might come back, that does not solve anyone's immediate problems. Therefore, incentivising long-term care would be an excellent way to do that.

Another way would be to fund research into the economic viability of preventative care. The evidence base and the economic evidence go hand in hand, but research can be expensive to secure, so perhaps support should be given to get the health economic modelling up and running. At the moment, the research is piecemeal, and a lot more effort must be taken in looking at exactly how we should be spending money more effectively for better decision making and better care.

Dennis Robertson: We have had a lot of good evidence. Helen Richens mentioned the patient pathway. Are we concentrating too much on the sectoral aspect rather than the patient pathway? I am not sure that enough is being done to prevent a patient from going into hospital in the first place.

Harry Stevenson mentioned discharge and the multidisciplinary approach. If we can prevent the patient from going to the hospital setting in the first place and provide the service that they need in the community, surely it would be better to do that? Richard Simpson made the point that 30 per cent of hospital admissions should not happen. Are we doing enough? If not, how do we address that problem?

I know that there is a good argument for the preventative approach but, when it comes to getting people to go to a community pharmacy or to preventing them from going into hospital, the issue might just be about the appropriate care package that they need at the time. That comes back to the question of social work provision.

Harry Stevenson: It seems to me that you are right. The issue is a complex one. Among other things, there are concerns in communities about access to the GP, the pharmacy and other services. Many people are known to all of us already anyway, as you well know. The issue is about having the ambition to make that a better journey. Perhaps somewhat clumsily, I was trying to focus on the community. The prevention agenda is really important here. What happens to someone when they arrive at a hospital is key, but there are a number of reasons why people end up at the door of that hospital and are admitted following attendance at A and E.

There are some excellent examples of good work being done across Scotland, and you have heard about some of them today. The question is how to learn from them and how to do more of the things that actually work and make a difference to people's lives.

Helen Richens: There are many good examples of preventative community-based work, which tries to prevent people from going into hospital in the first place. It was clear from the Audit Scotland report "Reshaping care for older people" that not enough was being done under that programme to shift resources into the community to support the running of those services. The Scottish Government's response to that report said that it was not just a case of shifting the resources, and that there will need to be new resource going into the community to support those services.

Dr Bennie: I echo, in particular, what Harry Stevenson was saying earlier about bridging finance. It is a difficult, chicken-and-egg issue. Do we close the beds or beef up the community service first?

My experience from when psychiatry hospitals were downsizing substantially was that there was generally sufficient bridging finance, certainly where I was in the west of Scotland, to allow the community resources to get up and running and functioning before the bed closure process. If that is not done, the programme falls at the first hurdle.

Dennis Robertson: Do we need to increase the primary care resources across the board in that multidisciplinary aspect, not just ensuring that the GPs or the appropriate specialist practice nurses are available but ensuring that the social care packages and staffing resources are available, too?

Kenryck Lloyd-Jones: Absolutely. There are certain key areas where we know that there are blue-light accident and emergency risks, such as respiratory conditions and heart conditions. We know that we can place services in the community that can support people and reduce the likelihood of them being admitted to accident and emergency, particularly at weekends. That prevention requires investment and, unfortunately, that requires a shift from acute to primary care. Therein lies an issue that has long been in place.

Richard Lyle: First, I wish to say that I think that the national health service in Scotland is excellent. I have always said that.

I will touch on a point that Nanette Milne made, and I may offend people, too. I believe that we must change our working practices. I say this with the greatest respect to Peter Bennie and Helen Richens. The BMA submission says:

"GPs are also providing a 7 day service through the out of hours services run by health boards."

The Royal College of Nursing submission says:

"nursing has played an increasing role in the delivery of out of hours care in the community".

Both your organisations are claiming credit. Before I became an MSP, I worked for the out-of-hours service in Lanarkshire as a driver, and I saw there and then what was being done by doctors. A small band of doctors came out to work at night. I saw the same doctors every week doing that. Not every doctor in Lanarkshire plays their part in providing an out-of-hours service. In fact, the out-of-hours service in Lanarkshire cannot fill all the shifts so it is having to shut down centres left, right and centre. I worked out of Wishaw, Hairmyres, Monklands and Lockhart hospital in Lanark.

GP surgeries shut at 6 o'clock at night on a Friday and do not open until 8 o'clock on a Monday morning. I go to my doctor once every seven years if I can help it, but other people go every week. Everyone else has changed their working practices for Saturdays and Sundays. I used to be a grocer; shops are now open 24 hours. If we go to any of the big stores—I will not name them—we can shop whenever.

With the greatest respect, I say that we need to look at the matter in reverse and see what we can do. Because the doctor is not open at the weekend, everybody goes to the out-of-hours service or to A and E. In fact, they do not want to wait in A and E for a couple of hours, so they phone up the out-of-hours service so that they can get an appointment, which they can do at any time during the night. I was there at 3 o'clock or 4 o'clock at night. When I was there, doctors were getting between £80 and £120 an hour, so they are well paid.

We have to consider weekend working practices and see what we can do best. I do not need to wear glasses so much now because I got two cataract operations done at weekends at two different hospitals in the past couple of years. Do you agree that we have to look at the matter in reverse and that doctors should provide more services locally to take pressure off A and E and other hospital departments?

Dr Bennie: I am guessing that you would like me to respond to that question. In many ways, you are talking about the things that we have been talking about during this evidence-taking session. There is a need to consider carefully what all professions within health and social services do and could do at weekends and overnight.

There is an out-of-hours GP service. It is not the same as the out-of-hours GP service 15 years ago, but that is because, to a large extent, the service 15 years ago consisted of every practice trying to cover its own patients, which was never sustainable and, arguably, was part of the reason why general practice struggled to recruit enough doctors.

We have a review of what is to happen with out-of-hours GP services. I will not even begin to suggest that you are entirely wrong about this. Out-of-hours GP services are struggling and stretched throughout the country, but we must think about who is best placed to do what at the weekends. That is what the task force is about.

Richard Lyle: The point that I am making is that everyone else has changed their working practices. Do doctors have to do the same, or will they do the same?

Dr Bennie: As I said, doctors worked out of hours and at weekends long before Tesco and the various other shops that are open all the time came around. Doctors are well used to providing the service that is required for urgent and emergency care and we still do that. However, there is a need to examine how the out-of-hours GP service is running right now. That is happening, so let us wait and see what comes out of that process.

Professor Dunn: I fully support examining the out-of-hours service for general practitioners. There is an issue, which we are recognising in the training of young doctors, in that general practice has moved more towards looking after chronic illness rather than acute illness. That is partly because some GPs have selected that.

Some GPs still enjoy the acute work and there is no doubt that a GP who knows his patient during the day is the best individual to decide the best place for that patient when they become unwell. However, there are resource implications and I hope that Lewis Ritchie's review will shed light on that and result in more interaction between primary and secondary care. I hope that some GPs will have spells in the hospital environment and that some hospital doctors will be trained to work in primary care. That would bridge the chasm between them well.

Kenryck Lloyd-Jones: Although GPs will always be key to it, the health system has moved on and we now have other health professionals with prescribing rights, such as physiotherapists and podiatrists—there is the prospect of other allied health professions coming on as well—who can, for example, prescribe antibiotics to somebody with a respiratory condition at the weekend or out of hours to prevent it from becoming a chronic condition that results in the person being blue lighted to hospital.

We should not stretch the analogy with supermarkets too far because, ultimately, they are trying to attract customers and hospitals are very much trying to reduce demand.

The Convener: We can all agree that, as the RCN said, we are not looking for a Tesco model for our health service.

We have had a good debate and discussion. Wide ranging though it was, I am sure that, like me, the other committee members appreciate the time that the witnesses have taken to come along and engage with us. Their written submissions are also greatly appreciated. I am sure that the discussion will continue because it cannot be divorced in any way from the future development of the health service to which we are all committed. I thank the witnesses all very much.

11:46

Meeting suspended.

11:52

On resuming—

The Convener: We continue with item 2. I apologise to the Cabinet Secretary for Health, Wellbeing and Sport for keeping her waiting around outside during the suspension and welcome her to the committee. The cabinet secretary is accompanied by Shirley Rogers, NHS Scotland workforce director; Ian Finlay, the senior medical officer in the Scottish Government's health workforce division; Anne Aitken, the programme director of the sustainability and seven-day services task force; and Liz Porterfield, the head of strategic planning and clinical priorities in the Scottish Government.

I invite the cabinet secretary to make a short statement.

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): Thank you for the opportunity to speak to the committee today. This is a big area of work that has the potential to make significant improvements in the care that is provided to patients across the whole week and to ensure that our health services are sustainable for the future.

In setting up the sustainability and seven-day services task force just over a year ago, we recognised that the NHS already delivers a range of services across seven days. However, we accepted that we could and should do more to ensure that those services are readily accessible, of high quality and sustainable. As you will see from the definition that was agreed by the task force, it has focused on removing inappropriate variation in the care that is provided overnight and at weekends to those who are acutely ill, and to those who are already in hospital and need support to progress through their pathway of care.

Sustainability is crucial. The work that the task force is progressing is looking at how we can make our workforce and our services sustainable for the future. We recognise the challenges of sustainability in remote and rural Scotland, and the task force has started considering ways to support those areas. It has also initiated some specific work around the sustainability of services in our six rural general hospitals, and there has been some early success with that work.

This is not a quick fix. It is a complex piece of work and some of the changes that it will lead to will take time to work through. However, that does not mean that we cannot take action now towards our aims. I have been encouraged by the progress that has been made by the task force to date and I welcome the next steps that are set out in the interim report that was published on 6 March.

One key theme that emerges from the report is about people receiving the right care from the right clinical team at the right time. For the majority of conditions or illnesses, that care is best provided locally by community-based healthcare staff. That means that our next steps need to involve examining ways of enhancing those local services by exploring new models of care, such as community hubs and the greater use of community hospitals.

Where more complex specialist care is needed, the service model might be a regional or even national one. The report sets out the example of major trauma services, where we are putting in place a network of care, including world-leading major trauma centres, to provide the best-quality specialist care for patients with severe injuries. That is absolutely consistent with our work on the integration of health and social care and the emerging national clinical strategy, all of which is aimed at improving services and clinical outcomes. It will benefit patients and make best use of our resources.

We need to make best use of the skills and capability of the entire healthcare workforce—nurses, allied health professionals, and our so-called back-room staff such as those who work in laboratories, including healthcare scientists. One of the next steps that was identified in the report is a review of the role of district nursing. Our nurses working in the community are crucial with regard to providing care at home for adults and children, particularly those with long-term conditions. We intend to consider what more can be done to enable advanced nurse practitioners to act as decision makers and to think about how we can make ward rounds at the weekends more effective. We know that some great work is already going on across Scotland and we need to build on that and spread it across all areas.

In addition, the task force is examining new models of care. The demand for diagnostic services has increased significantly over recent years. Through the first tranche of the performance fund, we are supporting increased diagnostic services at weekends. Alongside that,

the task force is specifically examining new ways of reviewing and reporting diagnostic imaging and the provision of interventional radiology.

With wide-ranging work such as that, it is vital that we link with and build on the range of national work that is already under way. Against the backdrop of the integration of health and social care and our engagement around the future of the NHS beyond 2020, we have recently announced a review of out-of-hours primary care services and we are developing a national clinical strategy, which is at an early stage.

I hope that I have given the committee a flavour of some of the work that is under way and of the early priorities of the task force.

The Convener: Thank you, cabinet secretary. Bob Doris will ask the first question.

Bob Doris: Good morning—just; it is almost midday.

I was interested in the cabinet secretary's comments about the effectiveness or efficiency of ward rounds, particularly at weekends. That links into evidence that we took from Frank Dunn, from the Royal College of Physicians and Surgeons of Glasgow, who talked about ward rounds not necessarily being able to facilitate decisions about when someone should be discharged because, for example, the pharmacist was not available to give the person medicine. We heard from Harry Stevenson of Social Work Scotland that there was perhaps no connectivity care package available to deal with such things as delayed discharge. We also heard about more junior doctors holding off from making key decisions because they wanted to wait until the consultant came around.

The issues seem to concern capacity building with regard to having the right medical professional making the right decision at the right time, but also ensuring that the allied professionals who need to be part of the team are available, too. In your opening statement, you talked about needing to make ward rounds more efficient, particularly at weekends. Can you give us more information on that?

Shona Robison: That is a key priority. The accident and emergency department performance measure shows that the spikes in delays tend to be at the beginning of the week, on Mondays and Tuesdays. Part of the reason for that is the delay in beds becoming available, because not enough discharges have happened over the weekend. Discharging starts to happen at the beginning of the week, so that is when the system comes under pressure. We absolutely need to get that right.

Part of that concerns who can make the decisions around discharge. A lot of work is being done on training for nurse-led discharges. Pharmacists' availability is key, and work is going on to ensure that pharmacists are available so that people can go home with all the medication that they require. Shirley Rogers can give you more details about that.

12:00

Shirley Rogers (Scottish Government): A number of elements contribute to a high-quality ward round. That includes the appropriateness of the decision maker and the availability of senior decision makers, and there are a number of factors around care packages, pharmacies and junior doctors. One of the principles that we are trying to work towards is encouraging people to work to the top of their licence. That is partly because of the delayed discharge issue, which everyone is familiar with, but it is also about the opportunity to intervene when a patient needs it, rather than them having to wait for a period of time before they see somebody who can help them.

It is still early days, but work that we have undertaken so far has involved looking at a number of hospitals and trying to make a qualitative assessment about ward rounds. Not surprisingly, we are demonstrating through that early work that the quality of ward rounds makes a real impact on delayed discharge decisions and, more importantly, on the quality of care that patients receive.

Bob Doris: I know that those things take as long as they take, especially when you are trying to develop working practices and build capacity with professionals. However, when do you think that some of that work will come to fruition so that this committee, or a successor health committee, can look at that work and see how it has developed—successfully, I hope—and how it has been rolled out across the wider NHS?

Shirley Rogers: As the cabinet secretary said in her opening comments, a number of pieces of work are coming together. The ward round initiative is already out there with boards as one of the top six priorities for unscheduled care. The work that the group is doing is contributing a qualitative assessment around that. I could typify unscheduled care by looking at the flow, time of discharge, accessibility of pharmacy services and some of the other things that were mentioned, and work is also being done with clinicians to look at what they find helpful in terms of ward rounds, confidence building around decision making, and the deployment of senior decision makers. It is already out there as one of the six priorities of unscheduled care, and we will continue to supply the qualitative data to support that.

Shona Robison: Boards are expected to get on with those six essentials in pretty short order. Over

the next few weeks and months, we want all that to be in place, not least before we get into next winter's territory. A lot of work is going on around that.

Bob Doris: I will make this my final question in order to let my colleagues in.

In my initial question, I mentioned the fact that pharmacists are key in the process, and we heard from Sandra Melville of the Royal Pharmaceutical Society in Scotland this morning. My question is about rolling out best practice. Health boards have the independence, under strategic guidance from the Scottish Government, to get on with the day-to-day job of running hospitals and ward rounds and everything else, but the committee visited a pharmaceutical initiative at Greater Glasgow and Clyde NHS Board that has centralised some of the dispensing facilities in the area. I forget the numbers, but that initiative has released nine or 10 clinical pharmacists to be on the ground doing clinical pharmacy reviews with patients at the outset of their visit to hospital, and they are more likely to be available ahead of discharge, too.

At face value, that seems to be an example of good practice. I do not know whether it is best practice—I have nothing to compare it with—but if it is, how can we roll it out across all the health boards to ensure that we get a high standard of service across the NHS?

Shona Robison: The once for Scotland approach is exactly that. If it works well, that is what we should be doing and it should be clearly communicated to boards. There might be some issues around what works in a rural general hospital or a district general hospital being slightly different from what works in a teaching hospital. Nevertheless, if something has been proven to work, the once for Scotland approach is that that is what should be rolled out. Boards are far more receptive to that approach now, because it is efficient and it has a huge impact on discharge. The logic and the evidence are pretty compelling.

Bob Doris: I said that that was my final question, but I have another one. Who would say, "This seems to be a really good model. It may or may not be suitable for your health board area, but we would like you to consider it. If you decide not to adopt it, that is fine but please give us your reasons for not adopting it"? Who pushes such initiatives forward?

Shona Robison: Shirley Rogers will say a bit more about that in a minute. Part of the reason why I have a regular meeting with chairs is that that is an opportunity for me to disseminate the key messages around priorities. We also have a performance management arrangement, whereby a lot of very experienced people in the Scottish Government have daily contact with boards on many of these matters. If something is working well, we expect the boards to get on and do it unless there are important reasons why they cannot.

Shirley Rogers: The cabinet secretary has given the general context. For certain things, it is sensible to have evidence and piloting, but certain things are no-brainers. The task force is underpinned by a board operational leads group and, when something is evidently sensible to do, the group members get that information directly from the task force and are empowered to go back to their boards to see whether the measure can be implemented at pace.

The evidence for some models is lighter because they are innovative models that are being developed, and measures sometimes make sense because they ease the flow of the patient through the hospital. If the measure is as simple as when they get their pharmacy kit supplied, board operational leads will take it back from the task force and see whether it can be implemented. We will want to hear from them if the measure cannot be implemented, for whatever reason. Some reasons might be legitimate but, if they are not, we will pose the question about how that good practice can be deployed across the service.

The Convener: I presume that the motivation behind the policy is the fact that there are variations in outcomes between people who receive care at weekends and out of hours. We had some discussion earlier about the evidence base for that, and I pick up from the points that you have just made that the evidence base may be variable. A patient's experience may be different if they present at a general hospital in a rural area rather than at a hospital in the central belt. We heard this morning the classic example that there is best practice at the Golden Jubilee national hospital, whereas there might not be elsewhere. What research has been done on those variations and what did that research tell you?

Shona Robison: Some issues are very clear. The six essential actions on unscheduled care came out of work that was undertaken by experts on unscheduled care into the six things that all hospitals—not just A and E departments—must do to ensure the most efficient and effective use of resources and people in order to achieve better outcomes for patients. That work was done and those six actions are expected to be delivered.

The evidence shows that, if hospitals do not discharge people at the weekend, there will be a clog in the system at the beginning of the week. Beds are being taken up by people who do not need to be there at the beginning of the week, which affects A and E performance at the beginning of the week because people cannot be

moved through the system. Such issues are very clear; other issues are less clear and, as Shirley Rogers said, we might run pilot schemes.

Sometimes we know what is not working well and the evidence is there because it has been tested—ward rounds were mentioned in that context. Some of it is not rocket science; it is just things that we know will make a difference and should be happening everywhere.

Some of the other areas are newer. It might be that we have to test out innovative things, because the evidence base is not as well developed as it is for other measures, which are more evidence based.

The Convener: I was thinking more about the quality of outcomes, mortality and whether people might run a higher risk if they found themselves in the sector out of hours, at weekends or on public holidays. I presume that that is what sets your priority. There is a variation that we need to deal with—we need to reduce the risk to individuals, which still exists while the task force is working. What does research tell us about hospitals in Scotland, quality of outcomes and the risk that people were experiencing?

Shona Robison: There is not a huge amount of evidence in Scotland around issues of mortality variation. There is more evidence from down south. As I set out in my opening remarks, the crux of the work has been how we ensure that we deliver a safe and sustainable service—the best possible service and the best possible outcomes for patients, no matter when they are in the system. That is why the early focus was on those who are already receiving services within a seven-day context, whether they are admitted over the weekend or whether they come through A and E in the evening. We have to ensure that the services for those people are safe, sustainable and of good quality everywhere. That was an early focus of the task force.

The task force has begun to look at the opportunities to do more diagnostics at the weekend. I guess that that is why the task force has looked at different elements. Part of it is about reassurance that our services are safe and sustainable for patients no matter when they come into the system. The other part of the work is to see what opportunity and capacity there is to do more across the seven days, such as more elective procedures.

The Convener: The international research and research from down south is accepted. I just wonder why we have not done research to ensure that, given that other research, patients in Scotland are not at risk as a result. Surely we should have been establishing whether there was that higher risk and doing something about that situation.

Shona Robison: We have the statistical information on mortality rates and ratios. All I am saying is that it does not show significant cause for concern. Nevertheless, it is very prudent of us to make sure that we have a safe and sustainable service—that is why it was an early priority. Even though nothing was alerting us to a particular problem with weekends or evenings, it was prudent for us to have the task force have an early look at that.

Ian Finlay (Scottish Government): You are right to say that we are doing this work because there was evidence from elsewhere that mortality was much higher at the weekend—it was at least 10 per cent higher. The initial look at Scottish data suggested that that probably was not the case in Scotland, as the cabinet secretary said. Nevertheless, we broadly accepted that there was a risk that that could be the case. We have a smaller system and it may be that, statistically, the data from elsewhere may be more apt. For that reason, we broadly accepted that the risk may well exist. That is exactly why we have developed a bit of scientific rigour in how we have undertaken the work. We have agreed to look to map the situation in Scotland at present and then to look at what we need and to bring proposals to you thereafter, for that very reason.

The Convener: You have been mapping it for a year.

Ian Finlay: We have been mapping a range of the priority areas, as outlined in the report, for the past year. We have been mapping what the service looks like and what is happening.

12:15

The Convener: And that brings you to some of the actions and conclusions.

Ian Finlay: It will do. The next step is to identify what constitutes a safe and sustainable service at weekends, to look at the difference and to see what we need to do. That will be the next stage of the work. This is really an interim part of the process.

Shona Robison: That work does not sit on its own. We are in the early days of work on a new national clinical strategy, which will be an important component of the work on safe and sustainable services.

The Convener: We might return to some of that if we have enough time. There seem to be lots of task forces and groups at work and lots of discussions going on, yet the situation has not changed—the risk still exists. The risk that you accepted might be there a year ago is still there,

because there has been no change in the system to reduce that risk to patients.

Ian Finlay: I guess that that is an interpretation.

Shirley Rogers: It is important to say that hospital standard mortality rates are one piece of evidence in a very complex picture. There are a number of factors that impact on whether a patient dies in hospital, some of which relate to the patient's condition and some of which relate to access to other facilities. A range of other factors come into play.

I do not think that we were looking for a digital solution. We were not trying to say that, when it comes to sustainability and seven-day services, there is one thing that we can do that will fix things. We were looking at a range of measures that would improve the quality of the patient's care and their experience over the seven days.

Mr Doris was right when he talked about variation in practice. There were some variations in practice, and we have been very blunt with boards in asking them to remove some of those variations. Some measures have been adopted as an overspill from the patient safety programme—for example, the use of surgical checklists. We have not waited for a report to be produced and to be issued to boards before saying that we have found good practices that seem to be beneficial in reducing risk. We have told the boards that there are things that they need to be doing now. I would not want to give the committee the impression that we are just thinking about doing something. A great deal of action is already being taken to improve hospital standard mortality rates and to improve the quality of care, the quality of decision making and overall patient outcomes.

The Convener: I am looking for information on the general context. It is very important from a political point of view that when a dramatic change is proposed—that is how the change that we are talking about was described to us by people who will be affected by it earlier in the meeting and in their written evidence—people are told why it is important.

The previous cabinet secretary sent out a confused message. Earlier, I quoted him as saying that the proposed move was about using the services and the workforce more efficiently at weekends and so on. Making best use of services and the workforce is important, but making the health service safer for people when they go into hospital is a different type of imperative with which we can get a lot more people on board, and it presents a different type of challenge. I am looking for the context. I wish that we had clear research that we were prepared to accept. The priority here is the outcomes.

Shona Robison: The point that Shirley Rogers made about the patient safety programme is critical. We have a world-leading patient safety programme. We did not wait for reports about patient safety issues. The patient safety programme is an example of us being on the front foot in looking at the best and safest practice across a range of areas, from how the front-door arrangements of a hospital are organised to ensuring that communication is right and to dealing with hospital-acquired infection.

We did not wait for the report on seven-day services, but it looks at the two issues that you identified: how we can ensure that we continue to deliver safe and sustainable services for everybody, regardless of when they come into the system; and how we can make better use of the workforce and the resources that we have over a seven-day period.

Dennis Robertson: I understand why we sometimes focus on acute services but if the aim is, as the cabinet secretary has mentioned, to ensure person-centred, safe, effective and sustainable care, we should be looking at how we prevent people from going into hospital in the first place. How do we use our community services such as community hospitals and community pharmacies much better to prevent patients from going into hospital in the first place? Are we, especially in remote and rural areas, using the available digital technology to do a lot of the work remotely?

Shona Robison: Your question raises issues that are key to how we go forward with the health service generally in Scotland. We focus a lot of our time and attention on one small bit of the picture when, actually, most people get their healthcare from the rest of the picture—in other words, from primary and community services. I am clear that we need to start spending more time on and giving more attention to that part of the system, and the task force is looking at that in the context of certain challenges such as the out-of-hours challenges. Lewis Ritchie's work on that will be very much aligned to the work of the task force.

There are huge opportunities. Yesterday, I was in Oban and Lochgilphead, where there is a rural general hospital model that can teach us a lot about how we might deliver services differently in an urban context. There are GPs who very much work to the top of their licence and have additional training and skills. In Lochgilphead, there has been a tremendous response to advertisements for vacancies, because it is an attractive proposition for GPs who want to do a variety of work during their week. There is huge excitement from the GPs involved about what more they might be able to do.

We can learn lessons from that model for the urban context, and we are looking at the task force recommendations in that respect. We are also doing work on how we might begin to provide more care and treatment in a community setting, both in hours and out of hours, to prevent people from going into the secondary and tertiary healthcare system when they do not need to.

There is huge potential in that area. Obviously, moving from the current system will give rise to challenges, but the opportunities could be attractive to GPs. At the moment, some areas are struggling to recruit GPs, and young doctors are choosing not to go into general practice because they want more variation in the work that they do. I am keen to create those opportunities. In all that, the benefit for the patient is that they get more of their care closer to home.

Dennis Robertson: Are we doing enough to ensure that the patient gets the appropriate service from the appropriate person in the community and that they have confidence in that person? You mentioned GPs, but patients might often have greater confidence in their nurse practitioner or even their community pharmacist. Are we doing enough to get the message across to patients that the people who work in the community are as essential to their care and wellbeing as the people who work in the hospitals?

Shona Robison: The GP is only part of the team. In Lochgilphead and Oban, the team that delivers in-hours and out-of-hours care includes advanced nurse practitioners, AHPs and paramedics. In a semi-urban context, the Clackmannanshire community healthcare centre brings together GP practices with nurses, AHPs and dentists and it involves close working with social care. It is a kind of one-door approach. The centre has developed some very innovative ways of working; for example, it has identified the cohort of people in the area who tend to make the most use of unscheduled care and has managed to reduce dramatically the number of hospital admissions, because those people are being kept safe in their own homes.

There are many such good examples, but the challenge for us is to spread that practice. The system in urban Scotland generally does not look like that, although we have some good examples of where such an approach is working. The challenge is the next stage. If the general consensus is that that could be a better model, the challenge is to shift from where we are and move towards it.

Dennis Robertson: Cabinet secretary, as you have suggested the question, I will ask it: how do we begin that shift?

Shona Robison: We are looking at testing the model in an urban context. We know that it works well in a rural context and we have some examples of it working well in an urban context, particularly in Clackmannanshire, but I would like to test it in a more urban setting. With a coalition of the willing—in other words, folk who want to be part of it—we could demonstrate that the model delivers a good level of patient care and is also sustainable. We are on the case, and I am happy to come back to the committee to share more details as we take the work forward.

Nanette Milne: As with our previous evidence session, this discussion has been very interesting. This is a huge area and many things have to be considered; for a start, the integration of health and social care clearly comes in to the roll-out of the possibilities of seven-day care. I presume that we will be getting an update on that at Thursday's debate on health, but how are things going along those lines and what is the buy-in of the various people involved?

We know that there is a great willingness, particularly by pharmacists, to be more involved in seven-day care. Presumably that will mean more negotiation of contracts, given that they are currently on five-days-a-week contracts. Is that the case, and can you give us any information on how easy or difficult that might be to achieve?

Shona Robison: Integration is a critical part of the way forward with the new models; indeed, it is critical that we have not just integration between health and social care but better integration within the health system. There are opportunities for that kind of integration to be much better than it is at the moment.

The high-level agreement between the Government and the Convention of Scottish Local Authorities on integration has been important, but it is probably more important that the partnerships on the ground get on with the job in hand. The signals are very positive and working relationships have been good. As you can imagine, they have been first out of the stall. Even in areas where traditionally there has not been great working across the systems, the change has really focused people's minds. Obviously it is a legislative requirement, but the additional resources have also helped to oil the wheels and assist people in considering new service delivery models.

What we do not want is the same old same old—in other words, two systems coming together, but offering the same services as before. The systems need to think differently about how to prevent admissions to hospital as much as how to ensure timely discharge from hospital, because those early wins are important.

We have asked the new integrated joint boards to focus on their equivalent of the 2 per cent of the population that use about 50 per cent of unscheduled capacity. That is what has been done in Clackmannanshire and that is what we would like joint boards everywhere to do. If we kept those people safe at home and avoided hospital admissions, that would be quite an early win.

As for your second question, we are not yet in the territory of contracts and conditions. There are processes and procedures for that, and they will be respected and recognised. It is fair to say that agenda for change recognises seven-day working, which is positive, but we absolutely respect the normal processes and procedures for taking this forward with other groups. I hope that people see the opportunity here. For GPs in particular, there is the opportunity to do things differently and to give the profession the chance to develop and change what it does, but we need to do that hand in hand. I hope that the opportunity is seized and taken forward but we obviously need to go through the proper processes of discussion.

12:30

Rhoda Grant: The first panel of witnesses this morning seemed to be united in saying that there was a disparity between services in the evenings and at weekends and those provided on weekdays and that that needed to be worked on. Is the interim report about evening out that disparity for emergency care but not scheduled care, or is it about moving the NHS to a 24/7 basis?

Shona Robison: As the NHS is not Tesco, not everything that is being done will be done 24/7. There are good patient safety reasons for not doing elective procedures at 4 o'clock in the morning, and there are huge complexities around discharging people at that time, even if we wanted to do so. We have to be clear what we are talking about.

We are already working across seven days but the task force is very clear about the need to ensure that such working is safe and sustainable. We then need to look at the opportunities for additional diagnostics, for example, at the weekend. Work is already going on around that, and the performance fund is being used to provide such additional diagnostic opportunities. Clinics already work at the weekend but there might be scope for more such work.

We have to be clear that we are not talking about trying to do what we do in the NHS 24/7. Given my earlier comments about patient safety issues, that would be neither realistic nor desirable. This is about ironing out some disparities, ensuring that what we do across seven days is safe and sustainable and looking at opportunities to do more. Diagnostics and discharge at the weekends are good examples in that respect. Some of those things would have big impacts on the system by making it more efficient and effective, and they are not that difficult to do. It is about the way in which people work, and having the right people, including pharmacists, in the right place at the right time to do all that. It might not be rocket science, but it is about bringing all of that together and ensuring that it flows over the weekend so that patients can flow out of the system.

Rhoda Grant: Patients' outcomes seem to be better during the week, because of weekday working and the fact that a critical mass of staff is available to do the diagnostics and the whole range of things required by someone needing unscheduled care. It seems that at the weekend the same range of staff, especially those involved in diagnostics—radiographers, pharmacists, those who work in the labs and porters, for example—is not available. How do we create seven-day cover to ensure that someone who comes in and requires a service gets it? How do we make that cost effective without looking at certain elements of elective work?

Shona Robison: Shirley Rogers will say a little bit about what Glasgow is doing to make radiology more effective and turn results around through seven-day working.

Shirley Rogers: Picking up a couple of issues that have arisen from what we have been talking about, I should say first of all that, for me, the question about rurality points towards the huge issue of rural sustainability, and I will give the committee two examples to illustrate what is already happening to help us with that.

The first is the community hospital that has been developed for the Western Isles. A range of clinicians and other NHS staff such as advanced nurse practitioners, paramedics, GPs in the overnight hours and a number of other colleagues has come together to provide that service. We know that GPs have exceptional patient assessment skills. As a result of introducing that new method of working and bringing that multidisciplinary team together, admissions to the Western Isles hospital have reduced by 17 per cent as evaluated. That reassures me that patients are getting good assessments, because a clinician with good experience sees them when they arrive at the hospital and they are pointed in the direction of the right kind of care. It also means that, instead of using the inelegant term "delayed discharge" to refer to people, we are talking about not having so many people going into hospital inappropriately in the first place.

We have talked a bit about the sustainability of the remote and rural workforce. A number of

things are already happening in Scotland in that respect, but I will give you just one example. We have undertaken an initiative with colleagues in Fort William, where a couple of consultant posts had been vacant for some time. Unless there is interest from people who have particular lifestyle or clinical practice choices, those opportunities do not always generate a huge number of applicants.

Working with colleagues in NHS Lothian, we were able to put together an educational experience and support package in Fort William, as a result of which we went from having no applicants to having seven suitable and appointable ones. It is quite something to have that number of applicants for some of our vacancies. We were trying to ensure that people who were drawn to remote and rural practice did not feel that, in making that choice, they were abandoned to nothing but remote and rural practice. The approach is really innovative and is now starting to produce shoots across the piece.

Dennis Robertson mentioned the use of digital support. There is no doubt that we are doing more in that area, but we are also starting to see real benefits from, for example, the development of the Scottish specialist transport and retrieval service—or ScotSTAR—which gives us the ability to retrieve patients and take them to the place that best suits their needs. We will doubtless come back with further evidence on ScotSTAR's effectiveness in due course, but it is already starting to show real clinical effectiveness.

As for Rhoda Grant's point about variation over the week, there is no doubt that there is some variation and that we will, as another colleague mentioned earlier, negotiate terms and conditions in that respect in due course. We have made it very clear from the outset of our work that the service models and patient requirements will determine the shape of those negotiations. That is really important, partly because that is what we are here for and partly because every clinician I have met has wanted to come and work in the NHS and do a good job. They want to be able to play the fullest possible part, and we want to be able to give them a service model to which they can pin their professional coattails.

Some of the work that the task force has seen relates to RCN proposals about the extended role that nursing and midwifery staff could play. The committee has already heard—quite persuasively, I think—from our pharmacy colleagues, who have a huge role to play. A number of others will come together, not least the paramedic cohort of the Scottish Ambulance Service.

Examples of that sort of work can be found all over remote and rural Scotland, from Buckie to Fort William, including certain initiatives in the island communities and the Clackmannanshire model that the cabinet secretary has already described. For general information, that model has produced a facility with three GP surgeries, two in-patient beds and 24 additional services that are available through advanced nurse practice and some social care partners who provide psychiatry support and other such services. It is no longer just a kind of tube with a fence that you could not climb through, and that is really important.

The radiotherapy services in Glasgow have not been redesigned so much as reorganised. That has involved bringing together a group of disparate services, which means, quite frankly, that there is a bigger rota, so there is an opportunity to run those services and make diagnostic support available to people across a wider range of times than simply 9 to 5 from Monday to Friday. Again, it comes back to the convener's point that we are considering not just the mortality stuff but the sheer effectiveness and efficiency that come together to produce a better patient outcome.

Rhoda Grant: Finally, we received evidence this morning that suggested that people are sicker at the weekend, which puzzled me slightly. Has any work been undertaken to see why people are sicker at the weekend? Surely weekends are good for people, not bad for them.

Shirley Rogers: I am not so sure that the human heart necessarily knows whether it will have a heart attack on a Friday or a Sunday, and I would not necessarily say that people are sicker at the weekend. What I would say is that, as any of you who have been involved in mental health care will be aware, some of the services that might help patients who experience difficulties at the weekend are occasionally more difficult to access. For example, when we looked at the spike in Lanarkshire's hospital standardised mortality ratio figures last year, some questions were raised about the availability of care home facilities at the weekend and access to care support and, to be frank, whether patients were being taken into hospital because, sadly, they were going to die and there was nowhere else that they could be.

I am not sure that I have seen evidence that suggests that people are actually sicker at the weekend, but there are issues about the necessary infrastructure and various other factors, which is why I made the point about the complexity of the HSMR. For example, the fact that families are now often fragmented means that people might notice that their parents, say, are poorly only when they visit them at the weekend when they might well have been poorly for a couple of days. A number of factors come together in that respect, and through our work, we are trying to ensure that the patient experience and the patient outcome are as good as we can make

them, that there is an opportunity for the whole clinical team to be involved in the decision making that essentially means that patients get a better outcome and that, where possible, we reduce variation wherever we find it.

Richard Lyle: Cabinet secretary, you said that the NHS is not Tesco. I could not agree more, but a number of years ago Tesco was not open on a Saturday and Sunday or open late, and now—

Shona Robison: That was a few years ago.

Richard Lyle: Yes, it was a few years ago. I worked in the grocery trade at the very start of my career and I never worked on a Sunday, but now people can go into most shops at 10 o'clock at night.

That aside, doctors' surgeries generally shut on a Friday at 6 o'clock and do not open again until 8 o'clock on a Monday morning, so the out-of-hours service has to cope with demand at the weekend. We are coming up to the Easter weekend, with surgeries closed on Friday, Saturday, Sunday and Monday, so out-of-hours services will need to cope with that.

When do you think we will get a seven-day service from our doctors so that people can get an appointment at a local doctor's surgery rather than attending A and E or an out-of-hours provider on a Saturday or a Sunday? Will we ever get to that?

Shona Robison: Yes, but it might involve a multidisciplinary team. The issue involves not just doctors but the role of advanced nurse practitioners and paramedics and the skill set on which we can build safe, sustainable out-of-hours provision that does not rely on one type of health professional for its sustainability.

Since 2004, when the responsibility for out-of-hours provision was removed from GPs and health boards took it on, we have seen the growth of various models that health boards have developed to try to provide that out-of-hours service. The primary reason—although there are a number of reasons—why I felt that it was important to review the arrangements is that, now that we are 11 years down the line, boards are continuing to wrestle with how they provide a safe, sustainable out-of-hours service. I felt that it was important to look at how we take a more coherent approach.

That might not mean that the exact same model that works in Glasgow will necessarily work in Mull or Tiree, but nevertheless Lewis Ritchie's review will look at the urban and the rural context, and at who does what at present and who could do what with the right skill set, training and support.

In some ways, rural Scotland has got to grips with the issue a bit better. I am not saying that there is not fragility in some areas, as there is, but some innovative solutions have been born out of necessity in parts of rural Scotland. For example, the extended use of paramedics and advanced nurse practitioners is more advanced in parts of rural Scotland in the provision of out-of-hours services than is perhaps the case in urban Scotland.

12:45

Lewis Ritchie is getting ahead with his work, and there are a lot of good people in his review group. We need the review to feed into the seven-day working agenda and to look at out-of-hours provision. That does not simply involve looking at GPs working out of hours; it must include in-hours services, the Scottish Ambulance Service, A and E and NHS 24.

Lewis Ritchie will be speaking to and working with those organisations closely to ensure that the recommendations that come forward can help to put out-of-hours services on to a sustainable footing. I want the service to be sustainable in the long term and to have more robustness and resilience behind it.

Richard Lyle: I have a final question—I know that other members want to come in. Do you agree that, if people could go to their local GP on Saturdays and Sundays, that would relieve pressures on A and E and on the out-of-hours service?

Shona Robison: Again, that might not be a GP who they see, although it could be a GP if that is what is required.

If someone needs to see a doctor out of hours, they should see one, but quite often they can be seen and treated, and equally well satisfied, by an advanced nurse practitioner or a paramedic. It is a matter of getting the right health professional to the person and ensuring that they get the support that they need. That might involve bringing in social care support for the person.

The service in Clackmannanshire operates a multidisciplinary rapid-response team, which is formed around a cohort of people who are the regular users of out-of-hours services rather than the occasional user. We must remember that 2 per cent of people use 50 per cent of unscheduled care capacity, which is a huge amount. A service has been developed specifically for those folk, which is rapid and responsive and gets the right person to them.

I do not want to come back to look at out-of-hours provision in a couple of years' time. I want to get a model that will stand the test of time—one that gives patients what they need by using the skills of the wider workforce rather than just GPs. GPs will always have an important part to play, but it is not just about GPs.

Dr Simpson: I will switch to the issue of hospital-based services. You have made a decision on major trauma units that I very much welcome, but my question is about the numbers of services that we have. The interim report states that we will have four major trauma units. I know that the Royal College of Surgeons of Edinburgh has mentioned two. Politically, two would be impossible, but is the evidence base there for expenditure on four?

The same applies to the mapping exercise that shows that we have 29 sites for acute general surgery and 21 sites for acute neurology; I am sure that the numbers vary for other services such as orthopaedics. We need to have a service that is effective. For a population such as that of Greater Manchester, there are probably two or three services.

I know that our geography, and the politics, are a problem, but if we are going to have effective weekend working without having people present for elective surgery, it might not be cost-effective to have people in only for emergency surgery on 29 sites. How is the workstream addressing the very difficult balance between what people want locally and what is effective and efficient, will save lives and is sustainable in the long term?

Shona Robison: The work on the national clinical strategy will influence a lot of the thinking. It will not be about the national clinical strategy saying, "Therefore, in such and such a location, you should have X." The strategy will lay out the evidence base around the best outcomes for patients across various specialties. That work is at an early stage, as you know, but it will be very important in determining some of those things.

There are other ways of delivering some of the services. Part of the difficulty at the moment is in recruitment and retention in some of the specialties, particularly within our district general hospitals. Obviously, patient safety comes first and we need to make sure that all our services are safe, but we need to change how we recruit for and deliver those services.

For example, Shirley Rogers described how we are moving to sustain some of our services within our rural general hospitals by linking some of the doctors, particularly within specialties, to the teaching hospital. Various networks are being established through that approach. In my view, there is no reason why a similar approach would not work effectively within our district general hospitals. We could have a far more attractive process of recruitment to some of the specialties if people knew that they would be working partly within a teaching hospital environment while also providing support to the district general hospitals. There is the opportunity to do far more of that across Scotland.

We need to allow the national clinical strategy to get under way to help us formulate the thinking on some of that work, but it is also a matter of making decisions that can overcome some of the recruitment and retention challenges in our system. We need to be far smarter when recruiting to posts—we need to recruit people to a network rather than to a particular position in a district general hospital. The fact that we still have vacancies within some of the specialties that are incredibly challenging to fill means that we have to look at that issue in a very different way.

Shirley Rogers: Dr Simpson is right—Scotland is a big place. Scotland is also a small place: in recruitment terms, given our population pool, we operate in a relatively small marketplace—committee members will be aware of that. Scotland is also, geographically, a very spread out place. We always have to consider access and the accessibility of services, particularly emergency services in life-threatening circumstances, in the context of that space.

The game is changing a little. We talked earlier on about scotSTAR—about retrieval services and so on. The cabinet secretary talked about recruitment. Recruitment has to have some regional context and some national context to it. If we are talking about perfusionists, for example, for which we have a tiny workforce, it makes little sense to me to have boards competing for that workforce. It makes much more sense to recruit for that specialty on a national basis and to increase the numbers overall.

Recruitment propositions will come out of the work. The cabinet secretary alluded to my earlier point about the relationships between hospitals. We are also doing quite a lot of work on expanding the approach to clinical fellows, for example, to give people exposure and an opportunity to look at things and to work in a specialist context. We may even look at the possibility of some specialist GPs. A number of universities are starting to talk to us about whether being a rural GP is a specialty. That seems to make a lot of sense.

Dr Simpson is right that there will always be a balance between the bigness that is Scotland geographically and the smallness that is Scotland in population terms. Our role is to provide evidence about what the best service is for patients and what it is reasonable for us to do in the staffing model.

Sadly, I cannot knit consultants any better than anybody else can. We have expanded that workforce considerably, but it is finite. Our job is to present the cabinet secretary with evidence-based options of how the service can be made more sustainable. It will be for others to decide on the acceptability of those options, but they will be based on the evidence of what we have seen.

We know that vascular surgery needs a population of 700,000 to 800,000 people in order for it to be at its optimum efficiency. That will take us to an answer. Whether it is an acceptable answer will be for others to decide.

Dr Simpson: If the outcomes are better, it will be acceptable and we have to demonstrate that.

I am very aware that the managed care networks model that we have adopted in Scotland is one answer. Although the King's Fund has said that the jury is out on it, I am convinced that it will deliver in the long term. At the moment it just involves the elective procedures and it works well. When I had my cancer, it was operated on in Glasgow by the Forth Valley NHS Board consultant, who went into Glasgow. The back-up team that he had there meant that his skills were managed well.

Two other health boards in the west of Scotland do not buy into that approach, which I think means that the outcomes are inevitably going to be poorer. That approach involves elective procedures; it will be really difficult to get it to involve the non-elective procedures—the unplanned emergency side. Do you have any examples so far in relation to non-elective procedures? Vascular surgery is probably the most developed example; is that working well with the five centres?

Liz Porterfield (Scottish Government): It is working well in two areas; it is not as advanced in one area but it is developing on a regional model.

The network model in Fife and Tayside has been successful in relation to the emergency side of things as opposed to the elective side. It is part of the overall development, and in the north services are coming together, too.

The west of Scotland is the area that had to look at where the optimal place for provision would be, given the paradigm of the population model in relation to having enough skills and being able to maintain and sustain the expertise. The boards are still looking at that. Again, that is partly about where the pathways naturally go for patients.

The work is being looked at and it is under way, and I expect to see more progress in the west, which is a bit further behind than the other two areas. We do keep asking about progress.

Dr Simpson: What particular field is that in? We heard from Frank Dunn that the west was very good—

Liz Porterfield: That is in vascular. The west is doing well, but more could still be done—the national planning forum keeps asking about how the west is getting on.

Dr Simpson: That is very helpful—thank you.

The Convener: We have spoken a lot about nurses and the clinical professionals, but the whole approach of delaying people from having to go to hospital and then, when they go there, getting them out more quickly, is putting a tremendous burden on community-delivered social services. I make a plea for all those who are involved in that. Is it not time that we considered the health and social care service rather than just the health service? The obvious question, which I think we all appreciate, is how they are going to pick up that additional work. Will that be funded?

The other issue is that a lot of the burden has been taken up by a lower-skilled workforce who are working in very stressful situations. That will also affect the outcome for patients who do not get to hospital. There is the 15-minute visit and the task-based approach. That workforce now deals with a myriad of people, including those with motor neurone disease, alcoholism, dementia, and other things that would put big pressure on professionally trained people. What are we doing through workforce planning to reshape and develop the workforce and perhaps give people the status that they are due in the process?

13:00

Shona Robison: Integration is the best chance that we have of bringing the two systems together. The course of travel that we decided on is to bring them together through legislation. I am optimistic that that will remove some of the perverse incentives of push and pull that we have seen in those systems. However, you raise an important point about where care staff sit in the team. There are issues around their pay and conditions, training and career opportunities. We have been talking to COSLA about how we can help local government and the sector to raise some of the standards and quality in the area. Discussions about the best way of doing that are on-going.

On career progression, there are opportunities to remove some of the artificial boundaries so that, having started off in the care sector, people can, with the right training and qualifications, move into jobs in the NHS far more easily. The same holds for people moving the other way; the work that nurses do in nursing homes is an example of an opportunity for skills to be developed and for such positions to become more attractive.

It is a challenge. Being part of a wider healthcare team will help. The model in Clackmannanshire that we have talked about a lot today does not rely only on care staff picking up the cases; it also involves district nurses, advanced nurse practitioners and a range of other staff supporting someone with dementia or with quite complex care needs in their home. That is important.

You are right that asking care staff alone to manage very complex care needs at home is not sustainable, which is why those staff need to be part of a wider team and supported in what they do. That is what we want to happen. We are discussing with local government how we can play our part to make that more likely to be the outcome. The opportunities to develop and better support that workforce are there.

Shirley Rogers: I have a couple of quick things to add, if I may. Part of my responsibility is to lead health and social care workforce integration, so we have regular dialogue with partners from local authorities, care homes and other suppliers about what other things we can bring together. We are at the early stages of that workforce planning, which involves ensuring that we have data that allows us to compare apples with apples and so on. We have recently launched a career framework that does exactly what the cabinet secretary says in respect of creating an educational ladder to give people the opportunity to expand.

There are two other groups that we have not talked about much and that have been fundamental to the task force's work. One is the patient representatives, who have been describing for us what they want. The convener described what it feels like to be at the end of a service. That input has been really important in shaping up that work.

I am also happy to acknowledge the incredible contribution of our trade union partners, who have been prepared to consider and help develop some of the models. That is not to suggest that we are going to hold hands and walk off into a glorious sunset when it comes to negotiations—there may be some difficult conversations around that—but the models are supported by the trade union partners, which is terribly important in demonstrating the case for change.

The Convener: It is good to hear that they have that voice.

The general point that I was making is that the NHS is a service but, in the care sector, which is where many of the people we are talking about go, we have the private sector, third sector, local government and different employers—it is not a system.

Shirley Rogers: You are absolutely right. I am not suggesting that all of that will be easy just because we have got those inputs; it will not. However, we can do a number of things together to start to make it feel like a real cohesive service for the patient or service user.

The Convener: The people who patients deal with every day are those at the bottom, not the social work manager or district nurse team.

Shona Robison: We are very conscious of that.

The Convener: There are no other questions and we need to move on. Thank you.

Subordinate Legislation

Public Bodies (Joint Working) (Scotland) Act 2014 (Consequential Modifications and Saving) Order 2015 [Draft]

13:05

The Convener: I hope to dispose of agenda items 3 and 4 fairly quickly. Members will be grateful to hear that they are the final items on the agenda. We have one affirmative instrument before us. As usual with affirmative instruments, we will have an evidence-taking session with the cabinet secretary and her officials. Once members have had all their questions answered, we will move to the formal debate on the instrument.

The cabinet secretary is joined by the Scottish Government officials Alison Taylor, the head of strategy and delivery—integration; and Clare McKinlay, a solicitor in the food, children, education, health and social care division. The cabinet secretary will make a brief opening statement.

Shona Robison: The order makes minor amendments to primary and secondary legislation all of which are in consequence of changes made by the Public Bodies (Joint Working) (Scotland) Act 2014. It also makes a saving provision to allow the integration arrangements that are already operating in the Highland area to transition into arrangements under the new legislation without a gap and at a date that is locally determined.

First, the order will ensure that integration joint boards, once established, have similar duties to those of health boards and local authorities, such as the requirement on them to give certain information to the provider of the patient advice service, through an amendment to include the joint boards as relevant bodies under the Patient Rights (Scotland) Act 2011.

Secondly, the order will ensure that certain other pieces of legislation will continue to work properly when functions are delegated under the Public Bodies (Joint Working) (Scotland) Act 2014.

Thirdly, the order will make the necessary changes following the repeal of section 5A of the Social Work (Scotland) Act 1968, which made provision for local authority plans for community care services. That updates the statute book to remove or replace out-of-date references.

Fourthly, the order will include a savings provision so that the arrangements made under sections 15 to 17 of the Community Care and Health (Scotland) Act 2002 relating to the Highland area may continue until they are replaced with integration arrangements under the 2014 act.

Members will wish to note that the order does not take forward any new policy, but I am happy to take questions on any of the modifications that it contains.

The Convener: Thank you, cabinet secretary. Are there any questions from members?

Rhoda Grant: I have a quick question. Does the order suggest that the Public Bodies (Joint Working) (Scotland) Act 2014 is not flexible enough to allow local arrangements to come into play where people can find a good way of working together? Highland Council and NHS Highland are probably the only bodies that have gone down the road of integration as they have, but is the legislation flexible enough to allow local arrangements where they work well?

Shona Robison: Yes, it is.

Alison Taylor (Scottish Government): Absolutely. The provision regarding the Highland authorities is there to ensure that they can continue to use the arrangements that they have already put in place until they move under the auspices of the new act. It does not have any bearing on flexibility for local decisions to suit local circumstances.

The Convener: As there are no other questions from members, we move to agenda item 4, which is the formal debate on the affirmative Scottish statutory instrument that we have just considered. I invite the cabinet secretary to move motion S4M-12645.

Motion moved,

That the Health and Sport Committee recommends that the Public Bodies (Joint Working) (Scotland) Act 2014 (Consequential Modifications and Saving) Order 2015 [draft] be approved.—[*Shona Robison.*]

Motion agreed to.

The Convener: Thank you for your time this morning, cabinet secretary. That concludes our business for today.

Meeting closed at 13:10.

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