OFFICIAL REPORT
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Health, Social Care and Sport Committee

Tuesday 9 November 2021

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 9 November 2021

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
10th Meeting 2021, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

*Paul O'Kane (West Scotland) (Lab)

COMMITTEE MEMBERS

*Stephanie Callaghan (Uddingston and Bellshill) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Evelyn Tweed (Stirling) (SNP)
*Sue Webber (Lothian) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Marion Bain (Scottish Government)
Dr Andrew Buist (British Medical Association)
Annie Gunner Logan (Coalition of Care and support Providers in Scotland)
Michael Kellet (Scottish Government)
John Mooney (Unison)
Colin Poolman (Royal College of Nursing)
Dr John Thomson (Royal College of Emergency Medicine)
Maree Todd (Minister for Public Health, Women's Health and Sport)
Sharon Wiener-Ogilvie (Allied Health Professions Federation Scotland)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 9 November 2021

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Gillian Martin): Welcome, everyone, to the Health, Social Care and Sport Committee's 10th meeting of 2021. I have received no apologies for this morning's meeting. The first agenda item is to decide whether to take items 4 to 6 in private. Are members content to do that?

Members *indicated agreement.*

Session 6 Priorities

09:00

The Convener: Our second item is an evidence session with the Minister for Public Health, Women's Health and Sport on her priorities for session 6. I welcome Maree Todd. This is the first time that the minister has been in front of the committee—I know that we have all got the "welcome to your new role" greetings out of the way, but welcome to your almost-new role. I also welcome the Scottish Government officials who are supporting the minister. Michael Kellet is the director for population health, and Marion Bain is a senior public health adviser, and they are joining us remotely.

I believe that the minister wishes to make a brief opening statement.

The Minister for Public Health, Women's Health and Sport (Maree Todd): Thank you, convener—indeed, I do. Over the past 18 months, the Covid-19 pandemic has put unparalleled pressure on all our lives and particularly on our health and social care system. I thank all our front-line health and care staff for their hard work and commitment in response to the pandemic.

Our response to the pandemic has shone a spotlight on new ways of working and has shown what is possible in the face of overwhelming need. To date, more than 10 million polymerase chain reaction tests have been undertaken, and we currently have 55 walk-through testing centres and eight drive-through testing centres. More than 1,000 pharmacies across Scotland are able to distribute lateral flow testing kits, and 3,500 staff are involved in testing across Scotland.

We have delivered more than 9.9 million vaccines since the vaccination programme began, and more than 2 million of those vaccines have been delivered as part of the autumn and winter programme. I am sure that the committee will agree that the work on vaccinations and testing has been outstanding.

The pandemic has been testing for us all, but the impacts have not been experienced equally. We are all in the same storm, but we are not all in the same boat. Covid exposed and exacerbated deep-rooted pre-existing health inequalities. People from minority ethnic groups, women, disabled people and those living in our most deprived communities have been disproportionately impacted by the pandemic.

In his previous report, the chief medical officer said:

"A healthier population could be one of our nation's most important assets and must be our ambition."

That provides a strong rationale for the need to invest in improving population health and in tackling health inequalities. It also sets the context for our plans for the parliamentary term ahead. Our long-term goal is to create a Scotland where everyone can flourish. Improving health and reducing health inequalities is vital if we are to achieve that.

As we remobilise and redesign our health and social care system, we need to ensure that we understand and address barriers that prevent people from engaging with and accessing health services. We are taking a range of actions.

Health screening is one of the most important prevention tools. It is vital that we ensure that everyone who is eligible to participate has an equal opportunity to do so. That is why we are making concerted efforts to tackle inequalities in uptake of screening.

We have exempted all young people under 26 years old from national health service dental charges, which is a first step in removing one of the barriers to accessing high-quality NHS dental care.

We are the first country in the United Kingdom to have a women's health plan, which outlines ambitious improvement and change across women's health. When women and girls are supported to lead healthy lives and fulfil their potential, the whole of society benefits.

We have committed to improving access to and delivery of NHS gender identity services. We will publish a national improvement plan by the end of this year, and we have committed to centrally fund service improvements.

Non-communicable diseases such as cancer, health disease, stroke, diabetes and lung disease contribute to more than two thirds of all deaths in Scotland every year. Sadly, most of those deaths are wholly preventable. We need bold population-wide approaches to reducing the significant harms of tobacco, alcohol and unhealthy food and drink. I intend to take a range of actions to drive forward that work.

We will introduce a public health bill that will include provisions in relation to restricting food and drink promotions, marketing and dissuasive cigarettes. We are developing an updated, high-impact tobacco action plan to ensure that fewer people take up smoking in the first place and to meet our 2034 commitment. We are also driving forward our alcohol framework and will consult on a range of proposals to restrict alcohol marketing, and to improve health information and product labels.

We will continue to invest in our alcohol and drug partnerships, which provide a vital support mechanism for people who are facing problems that are caused by alcohol and drug use.

Our recently published out of home action plan will support families to make healthier choices when eating out or ordering in, and we will provide more support to parents and practitioners on healthier food, healthy weight and healthy eating patterns to support children to eat well.

We continue to support boards to innovate and improve their weight management services by enhancing their digital solutions. The links between physical activity and health are well known, and our vision is for a country where people are more active, more often. That is why we are doubling investment in sport and active living to £100 million a year by the end of the current parliamentary session.

Through our Scottish women and girls in sport campaign, we continue to shine a light on the vast amount of great work that is being done across the sector to support women and girls in sport at all levels. I was delighted to see that the fifth campaign, which was held recently, was such a success, with wide collaboration. That highlighted some of the examples of how sport and physical activity supports the health of women and girls from across the country.

We need to create the conditions that nurture health and wellbeing, and that responsibility needs to be shared widely across many different organisations, sectors, communities, and individuals. The potential impact of that combined talent, expertise and commitment is huge. I am under no illusions about the enormous size of this task, but by continuing to work together, learning from our recent experiences and building on our successes, I am confident that we can make lasting change that will improve the health and wellbeing of everyone in Scotland.

The Convener: When society is faced with something like a pandemic, it reacts to it. Minister, you have been talking about a proactive and preventative agenda and the danger of that disappearing. You have outlined a range of measures that you want to take forward under your portfolio. How will the proactive and preventative agenda manifest itself in local areas? What can we expect to see in the next year or so that will make a difference and mean that people get that early intervention and proactive approach to their health?

Maree Todd: We will see a number of significant differences, but the first thing to do with that question is to reflect on what the past 18 months has given us. It has been an exceptionally challenging time and it is hard for us all to think of any positives. However, some positives might have come from the campaign over the past 18

months. A light was shone on pre-existing health inequalities, and I feel strongly that Scotland is unwilling to tolerate those any longer. As a Government and as parliamentarians, we have a mandate, and we will be able to build consensus and take bold steps in tackling some of those inequalities.

If we think about how difficult it was when this new virus hit us and we had no infrastructure in place, and we talk about how much testing and vaccination we have done now, it is almost hard to remember that, at the beginning of the pandemic, what we did time and again was the impossible. As a Government, we have a taste for that. We achieved the impossible because we worked together and turned to face a common enemy. That is powerful. We have found ways of working together and collaborating that will stand us in good stead.

We have seen significant behavioural changes, although not right across the board. There are still inequalities in the behavioural changes that have impacted people in the past 18 months, but we have seen people making such changes as socialising through exercise, for example, or working from home and making sure that they take time to go for a walk at lunch time. We need to hang on to those behavioural changes. Members will certainly see work going on to try to encourage people to be physically active during their working day. We already have the daily mile, which is fully integrated into schools. Many schools are signed up to that, and we want to be a daily mile nation. We want everybody to have the opportunity to exercise every day.

My sense is that there has been an increase in health literacy. People know where to go for high-quality information. NHS Inform was already quite a trusted source of information, and it has now become the first point of contact with the health service for many people. That will stand us in good stead. People are looking at local data for the pandemic and infection rates, and are making risk assessments. There have been significant behavioural changes over the past 18 months that will stand us in good stead as we move forward.

On prevention, we will have to take bold steps on big issues such as non-communicable diseases and, on diet and obesity, we will have to take bold steps to tackle the obesogenic environment. That means that all of us will have to come together collectively to take steps to make it easy for the population to do the right thing. We will see consultations and work on all those things—on alcohol, tobacco and diet—over the next few months.

As I said, a public health bill is coming. That may not be in the first year, but members will see work in advance of that bill over the next year.

The Convener: My colleagues have questions about your public health priorities.

Sue Webber (Lothian) (Con): We know that there is a lot of publicity around the drugs crisis that Scotland faces. The alcohol aspect of that is in your remit. People with alcohol dependence also need support and treatment. You have spoken a lot about what you are doing in relation to advertising and, obviously, there is minimum unit pricing. What is the Scottish Government going to do to help people with that dependence to access treatment and support? How might that link into the plans for the national care service?

I hope that that question was not too complicated.

Maree Todd: No, that is fine.

Drug and alcohol services are often combined on the ground, so much of the work that is led by my colleague Angela Constance in respect of investing in drug and alcohol services will benefit people with alcohol dependence, as well.

You are absolutely right to highlight alcohol as a priority. We saw a rise in alcohol deaths over the course of the pandemic last year. That bucked the trend over a number of years. We have done a lot of work on that front, and we were starting to reap the benefits of that. Last year, we saw a 17 per cent increase in such deaths, which was devastating and tragic for those affected. We saw an increase in such deaths throughout the United Kingdom; in fact, the increase in Scotland was slightly smaller. There was a 20 per cent increase in the rest of the UK and a 17 per cent increase in Scotland. That is probably testament to some of the policies that we have in place.

In the work around alcohol prevention and treatment, we are driving forward our alcohol framework, which has 20 actions to reduce alcohol-related harm and which enables the World Health Organization's focus on tackling the affordability, availability and attractiveness of alcohol. The key aspect of that work is minimum unit pricing. Like everyone here, I imagine, I think that that is a wonderful, well-targeted and effective policy. We committed to reviewing it within two years of its introduction but, unfortunately, the pandemic prevented us from holding that review. We have begun to gather information in order to review the minimum unit pricing of alcohol.

We are undertaking a range of work to improve alcohol treatment services throughout Scotland, including on a public health surveillance system and implementation of the UK-wide clinical guidelines for alcohol treatment.

Sue Webber: Is there anything specific in terms of that access to the rehabilitation services that

you have at this stage, or is that still very much being scoped out?

Maree Todd: What do you mean?

Sue Webber: If someone needed support right now, there are gaps. How would they get access to treatment? As you have said, there has been a rise in the number of alcohol-related deaths. That leads me to believe that there are perhaps more people out there with an issue with alcohol who are seeking support and help right now. That is a more specific issue.

09:15

Maree Todd: All over the UK, we found that people who drank heavily drank more during the pandemic, which I think largely explains the alcohol deaths. Twenty-three people a week die as a direct result of alcohol. As part of the national mission to tackle drug deaths, there has been increased investment, which is used by alcohol and drug partnerships all over the country. Those services are not separate on the ground—the alcohol and drug partnerships are the structure that is in place.

The investment to tackle the national drug crisis also supports people with alcohol addiction problems, and additional investment of £100 million to increase the availability of residential rehabilitation will benefit people with problematic alcohol use.

We recognise that more can be done to reduce the harms and increase help with treatment and recovery, but since 2008 we have invested more than £1 billion in tackling problem alcohol and drug use. This year, we are spending £140.7 million on the issue of alcohol and drug use.

Sue Webber: I have a further brief question. I should declare that I am a member of the Edinburgh Drug and Alcohol Partnership; we had a meeting last week.

The point is that, yes, the money is coming, but it is all being spent on the drug-related aspect. I am worried that the alcohol element, although part of ADPs, is getting left behind.

Maree Todd: I assure you that alcohol is equally a priority. Angela Constance and I work closely together, and we are determined not to introduce further silos in that work, which is profoundly unhelpful for the people who are accessing help. The money is intended to improve alcohol and drug partnerships and shore up the services on the ground, which will benefit people with alcohol problems.

Sue Webber: Thank you, minister.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): You spoke about shining a light on pre-existing health inequalities and their drivers. The Christie commission report has been around for quite a long time now—it has a big anniversary this year. What progress has there been with regard to the findings of Christie?

Maree Todd: You are absolutely right—it is an unwelcome reality that, across our society, communities experience health, quality of life and even life expectancy differently. That is not acceptable, and improving health and reducing health inequalities across Scotland are a clear ambition for the Government.

The pandemic has both exacerbated health inequalities and heightened awareness of the people we need to protect. The first thing that we all need to be clear about is that the solution to health inequalities will not lie entirely in my portfolio. Health inequalities relate to inequalities in wealth and power. The solutions to health inequalities lie in, for example, tackling poverty, which is a high priority and a mission for the Government.

We absolutely have to tackle the socioeconomic inequalities. I will bring in Michael Kellet to tell you a bit more about how we recognise that our health and social care institutions can be anchor organisations in tackling socioeconomic inequality, by offering good employment opportunities and leading the way in good work practices. We have a fair amount of work going on in that regard.

On preventative policies, Christie's work was incredible, and it is always important that we reflect on whether we have made the impact that he hoped we would. I do not think that we have, but we have done some pretty impressive work. If you think about the issue of alcohol, you will see that much of the effort that we put into tackling the problem relationship that we in Scotland have with alcohol is preventative. Much of that work is bearing fruit, but the issues are difficult to tackle and it will take longer for us to feel the benefits of that.

In the past year, there was an increase in the number of alcohol-related deaths all over the UK. No death from alcohol is acceptable and it is devastating that there was an increase last year. However, the slightly lower increase in Scotland shows that preventative policies are bearing fruit here. Although we had an increase, it was not as high as elsewhere in the UK. That can largely be attributed to our preventative policies, such as minimum unit pricing of alcohol, which is a policy that every one of us should be proud of.

Stephanie Callaghan: I accept that we have been doing things on that. When taking evidence, the committee has often heard about how health professionals' focus tends to be on the targets that they are measured on. How do we ensure that

prevention and inequality are suitably prioritised? The health professionals said that those matters end up being pushed to the side because they have other numbers that they need to hit. We all know about what is measured.

Maree Todd: Health services throughout the world are often criticised for being reactive rather than preventative. There is a lot more that we can do to ensure that people live long, healthy lives and that we prevent illness before it happens. We can support people to stop smoking, prevent people from drinking too much alcohol and make the food environment easier to navigate so that is easier to eat healthily than it is to eat unhealthily. We can do all those things, but they do not necessarily sit on the health professionals' shoulders.

There are also actual health issues involved, too. For example, picking up and treating hypertension is an important preventative strategy. Much of that work lies in primary care.

I will bring in Michael Kellet. I mentioned the work that we are doing with the Convention of Scottish Local Authorities, the NHS and universities—a lot of public services—on using anchor institutions to change the health of the communities that they serve. That is exciting work. It is an exciting approach because it takes the burden off the healthcare professionals who are at the coalface but uses our NHS to improve the nation's health. It is quite a clever way of doing it.

Michael Kellet (Scottish Government): The work on anchor institutions is a really interesting agenda. Part of my role is to work across the Government with colleagues who work in the communities, education and economy portfolios on that agenda, which is gaining momentum. It is about thinking about the powers of the NHS and social care services as institutions.

The NHS employs more than 150,000 people in Scotland and there are many more in social care, too. The agenda is about thinking about how those institutions employ people, which people they employ and how they use their power as contractors for local services as an instrument of social good and to tackle inequalities.

We are working with NHS boards and health and social care providers on that agenda. We also work in local partnership as well. It is important that NHS institutions work with councils and colleges locally to think about how they employ people and tackle some of the agenda.

NHS National Services Scotland and NHS Education for Scotland are pioneering work on the youth academy. They are thinking about how to bring into training and work in health and social care young people who would normally be disadvantaged and excluded from those programmes. A lot of work is going on with that.

I echo the point about the need for further progress on the Christie agenda. We recognise that. The Covid recovery strategy that was recently published by the Deputy First Minister and the work on child poverty both recognise that we must work across the Government on the social determinants of population health. We are doing that. I agree with the minister that the pandemic has increased intolerance for health inequalities and has made that work even more important.

Stephanie Callaghan: There have been recent announcements about priorities relating to place and wellbeing and about preventative and proactive care being based in communities. That might involve 20-minute neighbourhoods, where people have different services to hand.

Maree Todd: The 20-minute neighbourhood is a win-win for public health. If people only have to go 20 minutes away and are easily able to access public services, active travel becomes more possible. If we design public services to be within walking distance of where people live, we are likely to have a more active nation than we would if we designed public services so that folk had to hop in a car and go to a centralised point.

That active nation agenda is vitally important. It ticks every box. The Government's priorities right now are to tackle inequality and climate change and to improve health. The active nation agenda improves every one of those. If people are more active, we reduce the number of cars on the road and the level of pollution. We will tackle climate change and will have healthier people.

The 20-minute neighbourhood is an important part of what we are trying to achieve. As ever in Scotland, that may be trickier to achieve in my part of the country.

The Convener: I am a rural MSP. For that to happen in rural areas, the infrastructure must be there.

Maree Todd: As a rural MSP, I am focusing on that. We must make sure that people in rural areas benefit as much as others. We should not default to centralising public services far away from them.

Carol Mochan (South Scotland) (Lab): I want to pick up on the minister's point that the situation with inequality has not improved in 14 years, and may have got worse. It is important to acknowledge the root causes of inequality and to focus on those. We have opportunities to tackle those causes in this session of Parliament. We could use carers allowance or increase the wages of low-paid workers. We could have had a right to food bill. Those things have not happened. Does the Government acknowledge that the root causes

of inequality must be tackled if we want to change health inequality? How will the Government work across portfolios to change things?

Maree Todd: We are working across portfolios. The Tory-Lib Dem coalition came in in 2010 and brought in welfare reform, and there is powerful and well-documented evidence that that worsened inequality across the UK. Some of those welfare reforms affected disabled people most severely, and some of the most vulnerable people in society suffered. In the past 14 years, while the Scottish National Party has been in Government here, the UK Government has systematically dismantled the welfare system and has made health inequalities significantly worse.

Despite that, the Scottish Government has done a great deal. Those who look at the UK as a whole would say that the Scottish Government prioritises health inequalities and poverty. Work to ensure adequate housing protects people in Scotland from health inequalities.

An awful lot of money is spent on, for example, mitigating the bedroom tax in Scotland. That tax, which was introduced by the Tory-Liberal Democrat coalition, punishes disabled people in particular, and people in Scotland do not have to pay it. If we are looking at what has happened over the past 14 years, we really have to look at the welfare system, too.

09:30

As for finding opportunities for mitigation, I again highlight the bedroom tax as a perfect example. If the Scottish Government has to spend money on issues that are reserved, that means less money for devolved matters, and there is a limit to how much of that sort of thing we can do. Every year, we spend millions on mitigating the bedroom tax, and that is particularly beneficial for disabled people in Scotland. As I have said, though, there are limits to how much we can do and how much we can spend. I am very proud that the Scottish Government has introduced the Scottish child payment and that, during this parliamentary session, we will increase that payment and extend it to all children. However, there are budgetary limits to what the Scottish Parliament and Government can do in the face of the systematic damage to the welfare system that is coming from our other Government.

Carol Mochan: Clearly there is a major problem with the UK Government's treatment of welfare and other benefits. Do you commit to feeding back to the committee just how far the Scottish Government is prepared to go with mitigation and in ensuring that we in the Scottish Parliament do everything that we can in this respect? As we have heard from other experts in these evidence-taking sessions, the key thing that we in Scotland can do is to change inequalities, and that in itself will help us develop Scotland further and use our budget in the best way.

Maree Todd: Absolutely. I am more than happy to write to the committee in more detail not only on the steps that we are taking but on what we are up against.

Gillian Mackay (Central Scotland) (Green): Good morning, minister. This issue that I want to ask about does not specifically fall within your portfolio, but it follows on from Carol Mochan's questions. At our public health stakeholder evidence-taking session, I asked the panel members whether they felt that a universal basic income could help to tackle some of the economic inequalities that lead to poor health, and Professor Sir Harry Burns, among others, agreed that such an approach would help. I know that the Government is undertaking work on a minimum income guarantee, so what role do you see that playing in improving public health? Are you working with the minimum income guarantee steering group on this matter?

Maree Todd: I will bring in Michael Kellet to give you a bit more information about the cross-Government work that is going on. However, one of the things that we in the Scottish Government have always recognised but which has become even clearer with the pandemic is that siloed working will not serve the citizens of Scotland. As a result, a great deal more cross-Government work is going on than there ever was before, and the Deputy First Minister, in his Covid recovery role, has a cross-portfolio role to ensure that policies join up across Government. There is work going on across Government on such issues.

On the universal basic income, health inequalities are, as I have said, related to wealth inequalities, so the solution to health inequalities lies in ensuring that people have an adequate income. We need to tackle individual disempowerment, and there are undoubtedly people and groups in our communities who are easy to ignore. It is not just a simple matter of tackling poverty, although that would go a long way towards tackling health inequalities.

My party is very sympathetic to the idea of a universal basic income, but we are not convinced that we can introduce it without the full powers of independence. As a result, we are exploring ways of assuring people in Scotland that they can have a dignified level of income, although I realise that that falls short of a universal basic income.

I think that you can see our commitment to such an approach in, for example, our handling of school lunch provision during the pandemic. It was quickly recognised that we should get money into

the pockets of parents so that they could feed their children adequately. That was brought in all over Scotland quite quickly, because that is the best thing that can be done to support families and the most effective way of ensuring that children are well fed.

Michael Kellet will say a little more about the cross-Government work that he is involved in.

Michael Kellet: I hope that members can hear me okay. I echo the minister's comment about the absolute recognition that addressing poverty and tackling inequalities in power, income and wealth are understood to be a central tenet of our approach to tackling health inequalities.

I reassure Ms Mackay that we are working with colleagues across Government on the agenda of tackling poverty in general, tackling child poverty in particular and exploring a minimum income guarantee, to which Ms Mackay referred. We will continue that work as a priority.

Maree Todd: Child poverty has lifelong impacts, so tackling it is absolutely the place to start and to focus on for prevention.

The Convener: It is interesting that you say that, because the committee is going to prioritise an inquiry into that very thing—children's life chances and the drivers of inequalities in children's health.

We will move on to the women's health plan. Gillian Mackay wants to ask questions about that, so we will stay with her to kick that off.

Gillian Mackay: I am really pleased to see work on endometriosis in the women's health plan. Like endometriosis, polycystic ovarian syndrome is a condition that women often struggle to be diagnosed with. PCOS is mentioned only briefly in the plan. On average, how long do women in Scotland wait for a diagnosis of PCOS? What work is being undertaken to improve the diagnosis and treatment of it?

Maree Todd: Dr Marion Bain, who is a deputy chief medical officer and was involved in developing the women's health plan, can give you a little more information about PCOS.

It has been suggested to me that a number of conditions should have been included in the plan. I recognise that it is not all-encompassing. The plan and its priorities were developed with input from women, and we agreed with women who have lived experience the areas that we should target first.

The plan is momentous and I love the fact that Scotland is leading the way with it. I am determined for the plan to deliver tangible change for women, but it is just a start. There is more to come to tackle the health inequalities that women experience as a whole.

The Convener: Your microphone is live, Marion.

Dr Marion Bain (Scottish Government): Can you hear me?

The Convener: We can hear you fine.

Dr Bain: That is great. Thank you for inviting me to speak. I had the great privilege of chairing the group that put together the women's health plan. The group was passionate about changing things for women's health.

As the minister said, the plan concentrates on a range of specific items, but underlying all that is ensuring that the issues that matter to women—including conditions that are specific to them—are better addressed in the health service. That is about all the conditions that are specific to women and particularly those for which waiting times are longer.

First, our services must be accessible to women, so that they can get there when they have concerns about their health. Secondly, we must have specialists who can advise on and treat the conditions. The third aspect is research. All those points are woven through the plan.

As it is taken forward, the plan should have an impact far beyond the specifics and should certainly have an impact by ensuring that women can access and are encouraged to access services earlier, when they can benefit from them.

Another of the key themes in the women's health plan is around ensuring that women have the information that they need to understand which symptoms they should be concerned about, and then also ensuring that our general practitioners and specialists have the information that they need to refer women on.

Similar groups will be involved as we move to the implementation. Concentrating on the treatment area that we are talking about, that will include GPs, hospital clinicians and specialists in different areas of women's health. It is about ensuring, first of all, that women understand when they need to go and see a clinician. It is then about ensuring that they are appropriately referred on, and that we have the treatments available.

I will make a last point about the research area. The women's health plan also identified that we need to ensure that we do the right research. A number of conditions are underresearched for women, and we therefore do not have enough information to really make strides forward. That is therefore also part of what is in the plan. I hope that that is helpful.

The Convener: I will pick up on the role of research. Anybody who has read Caroline Criado Perez's book "Invisible Women" will know that, for years and years, there has been a lack of research considering women in relation to common health conditions, for men and women. That has had implications for women.

How much of a priority is it for Government to undo some of that injustice in relation to historical research and—going right back to basics—through the training of our health professionals? That seems like a substantial piece of work that needs to be done—this is only a start.

Maree Todd: It is a substantial piece of work. One of the things that I always say is that we have to understand the health inequalities that women have faced; if we think about the reasons behind the women's health plan, it is about inequalities in wealth, power and income. Added to that, there have been millennia of mythology and fear about women's bodies, which will not be undone quickly or easily. However, I think that this is a perfect moment in time to make tangible progress, and I am convinced that we can do that.

The convener spoke about research. One thing that is very clear is that evidence shows that women's heart attacks are underrecognised and that, even when they are recognised, they are undertreated. That is one of the reasons why women's heart health is a priority. Women are less likely to be put on to the battery of preventative drugs that are routine for men who have heart attacks.

Women's heart attacks are often referred to as having an atypical presentation. However, the reality is that, for women, it is not an atypical presentation, but a perfectly normal way for women to present with a heart attack. It simply does not look quite like the way that men present. That is absolutely an insight into the situation that we face. It really is a man's world—the world is built around the way that men present and the treatment that men need.

To be fair, there are some reasons why that might be. I am a pharmacist by profession and so I know that there are questions of ethics around women, particularly child-bearing women, participating in clinical trials of new drugs. However, most health professionals say that, as they went through medical school, the default setting was men's bodies, men's presentations and men's illnesses. Marion Bain might like to reflect on her own experience of that.

Dr Bain: That is absolutely right. It is very much a culture thing. What was considered normal when I trained is, when we think about it, completely not normal, because 50 per cent of the population are women. We need change to ensure that we think about all the population and that there is a focus on how women present and respond as well as on the wider aspects of what makes it easy or difficult for women to access both information and services.

I completely agree that we need change, and some of that is already happening. Of course, more than half the medical workforce that are coming through are women, which helps to ensure that we focus appropriately on women's health and change what was regarded as normal but is not. It also helps us to focus on the things that we want to change as we move forward, especially with the women's health plan.

09:45

The Convener: Emma Harper will ask a short supplementary question, after which I will come back to Stephanie Callaghan.

Emma Harper (South Scotland) (SNP): Research is under way on cervical cancer screening by self-sampling. I know that in NHS Dumfries and Galloway, 25 per cent of the 6,000 women who previously defaulted on screening appointments have taken that up. That means that 1,500 women are now self-screening. Can you give a short response on where we are with that research?

Maree Todd: You are right that self-screening is being trialled in Dumfries and Galloway. It is initially being targeted at women who are not presenting for screening—that is, those who are not taking up the offer of cervical screening. Uptake is increasing through the use of self-screening.

You highlight one of the big challenges that women have in accessing healthcare. Women might have caring responsibilities that mean that it is impossible for them to go to an appointment, but that is not the whole story on cervical screening. One of the real problems is that the test is invasive. As we know, many people have experienced sexual violence and going for a test of that nature is a barrier that they cannot overcome.

I can see that some women would find self-screening at home helpful. The challenge is that we have not yet had a test validated or recommended by the national body to say that it is appropriate. As soon as that happens, we will have procedures in place to use it, but we are not quite certain of the technology yet. Dumfries and Galloway is just one of the areas in the UK where work is taking place to ensure that the quality of the test is sufficient to use nationally.

The Convener: Before I pass over to Stephanie, I remind members that we have much

to cover. The thing about public health is that there are so many plans—[*Interruption*.]

Maree Todd: Tell me about it! [*Laughter*.]

Gillian Mackay: I will pick up the pace, because members want to ask about other plans. Stephanie will ask the final question on the women's health plan, and then we will move on to the best start plan.

Stephanie Callaghan: Thank you, minister; and thank you to Marion, too. There is not much at all in what you said that I could disagree with.

We know that the women's health plan is not all encompassing. I am thinking of conditions such as menopause, hyperthyroidism and even endometriosis, which I have suffered from. The number 1 point that we must address is that women are dismissed and disbelieved, as we have seen with the mesh situation.

When I was suffering from endometriosis, it took more than 10 years to get a diagnosis, as has also been the case for so many others. The disease was really severe and I have had several operations. I have a daughter and, like every parent, the last thing that I want is for her to go through the same thing. She is getting to the age at which she might be affected.

Great training is provided in medical school, but how do we propose to change the deeply embedded attitudes to women who present with health issues? A lot of the time, the attitude comes from the top. It is not just male doctors or consultants who are the issue; females can be just as bad. In my experience, the same dismissal of and disbelief in what we say has been apparent in relation to not only women's health issues, but to our children's health issues. How will we tackle that?

Maree Todd: You are talking about broad cultural issues. As I said at the beginning, people suffer health inequalities because of inequalities in wealth, power and income. The power aspect is really important. If we move beyond the women's health plan, you will see that, across the NHS, we are trying to provide a patient-centred service. Realistic medicine, for example, is very much about sharing power between patient and health professional, and coming to decisions together. A great deal of work is being done in that area, but there is a great deal more to do and women are more disempowered than most; you are absolutely correct about that. One of the ways of correcting that is through information. I say time and again that information is power. We have put a lot of effort into ensuring that NHS Inform, for example, has good high-quality information.

One of our challenges is, however, the level of understanding of what is normal and what is abnormal and might require help. That is not great in our population. Since I became the minister for women's health, I have talked about the mythical status of women's bodies and the fear that people have of them. I am 48—nearly 50—and when I started my periods, people were still talking about "getting the curse". The language that was used was so incredibly stigmatising. How could anyone possibly imagine that that was anything other than a bad thing? How would you know to go and get help if you were anticipating a curse?

We are tackling many issues, right across the board, through education in schools at every opportunity. Throughout her life, there are multiple opportunities to offer a woman information about her health, and culturally we are trying to shift the dial.

Some of this work sits outside my portfolio, such as the work to tackle income inequality for women and close the gender gap. That will be important for empowering women so that they can navigate the healthcare system without being dismissed and disempowered in the way that you describe. It will not happen overnight, however, and much of it reflects our general culture. That is the reality of the world we live in. Even in 2021, it is still a man's world.

The Convener: I afraid that we will have to move on. As with all these subjects, we could spend 90 minutes just talking about each one.

Emma Harper wants to ask about the best start plan.

Emma Harper: You have outlined a lot of what is being presented by the Scottish Government such as the child support payments and so on. I am interested in how the best start plan is working in rural and remote areas. As the convener said, she represents a rural area, as do you and I. How are we supporting the people who live in rural and remote areas?

Maree Todd: Do you mean through the maternity services?

Emma Harper: Yes. I am interested in the best start plan and I know that we have problems with maternity services on my patch.

Maree Todd: I might bring in Michael Kellet to speak to this. One of the big challenges that we have in Scotland is that one size never fits all. In my constituency, delivering public services in the far north-west of Sutherland is significantly harder, given its geography, topography, and population sparsity, compared with a city. Inner cities, however, have their own challenges, such as poverty and access to transport and all sorts of things. There is in Scotland a recognition that one size does not fit all. That is important, especially from a patient's perspective so, as I said, one of

the things that we are trying to do with realistic medicine is to offer people person-centred care and flexible services that work for them.

Much of the work on implementing improvements in maternity services had to be paused as we turned to face the pandemic, but we are starting to pick that work up again. What you will see, I hope, is a family-centred service that recognises how important the family unit is to a child's health. That is one of the reasons for the payments to support families when they are visiting children in hospital. There is plenty of evidence that shows the impact that such payments can have.

The day that I launched that service, I met an amazing woman whose child was in hospital with a long-term condition. She had had to change her job to a much lower-income job to be able to continue to visit her child in hospital. She said that when she arrived at hospital the costs racked up on her credit card almost immediately, so those payments will make a significant difference. We recognise that family are not just visitors; particularly in relation to neonatal care, families are an essential part of a child's care. That illustrates our most significant strides towards that family-centred approach.

Michael, do you want to add anything?

Michael Kellet: I do not have much to add. I recognise that the work on implementing the best start plan has been impacted by Covid, as the minister said, but colleagues are progressing that. That is not in my portfolio in the Scottish Government; there is another director in health who looks after that agenda, but I know that the priorities around continuity of care, person-centred care and multiprofessional working are real. It will be challenging to implement those in rural as opposed to urban areas, but the principles persist and need to be implemented.

Minister, I could endeavour to write to the committee with more detail on Ms Harper's question if that would be helpful.

The Convener: We will come back to the issue. The minister will be aware that we are doing a perinatal mental health and new mother care inquiry.

I am conscious that we have a lot to get through, so I will move on to the active Scotland delivery plan.

Evelyn Tweed (Stirling) (SNP): I was interested to hear your comments about the pandemic and the fact that for some people it was a good opportunity to get physically active, get out and about, go for a walk and get the benefits of working from home. How can the Scottish Government hold on to the progress that was made and what can it do to make sure that access to physical activity and exercise is not too costly?

Maree Todd: That is a great question and one that we mull over all the time, because we are trying to harness those benefits and ensure that they reach those parts of the population that were not able to change their behaviour during the pandemic. Physical activity and sport are central to Scotland's recovery. I recognise that obesity is a risk factor for severe illness and death relating to Covid, so it is more important than ever that we tackle it.

The link between physical activity and sport and mental wellbeing was already strongly established, but many people have recognised that on a personal level over the course of the pandemic. I cannot be the only one here who found that the opportunity to get outside in the fresh air, connect with nature and say hello to my neighbours, albeit from a 2m distance, was the most precious thing that got me through the pandemic on a daily basis.

Sports clubs have done an astounding job and we recognise how important they are to their communities. Many sports clubs across the length and breadth of Scotland have stepped up during the pandemic by meeting the needs of vulnerable people in the population. Sport has a reach that we as parliamentarians or Government do not have; it reaches people whom we cannot.

We are reflecting on all that. Over the course of the past 18 to 20 months, as you would expect, relationships between the Government and the sporting sector have been strengthened significantly. That is not to say that it has always been easy, but, boy, we have had to work really closely together to rise to the challenges that the pandemic has thrown at us in order to bring back sport, which is something that we love. Those strong relationships will see us through the remaining tough times of the pandemic. They will also help us work together to tackle the broader health of the nation.

10:00

As I said, we are pretty keen to do that, and it ties in with action on climate change. I have already had a bilateral meeting with Patrick Harvie, the Minister for Zero Carbon Buildings, Active Travel and Tenants' Rights. Increasing activity in relation to transport is part of tackling inequalities, because anyone can walk and you do not need special equipment to do it. Ensuring that we have 20-minute neighbourhoods that are nice to walk in and in which you can access public services and tackling the provision of that infrastructure are important parts of delivering our aims. That will require us to work together and to

keep things in focus, but I am absolutely determined that there are opportunities there.

Finally, on the active Scotland delivery plan, we do pretty well in that we buck the international trend and increase our activity levels, which most people would be surprised to hear. Much of that is about active transport, so that is something for us to focus on.

The Convener: Sue, if your question is a quick one, I will allow you to come in.

Sue Webber: Yes, it is. Thank you, convener. My colleague mentioned the fact that sport is perceived as costly, but, often, that cost is related to access to facilities, which is associated with charges payable to local authorities. What can you do to ensure that the costs to the clubs and participants are reduced and that local authorities keep rents as low as possible?

Maree Todd: We are doing a couple of things on that. We are doubling investment in that portfolio area over the course of this parliamentary session. That investment will be focused on tackling inequalities and ensuring that everybody can access sport and physical activity. Over the coming year, we will work with sportscotland on next steps to ensure that, as a first step, the active schools programme is free for all children and young people by the end of this parliamentary session. That will provide more opportunities for children and young people to take part in sport.

You are absolutely right, however, that many local authorities have divested themselves of estate and we are keen to address that. We are setting up a fan bank to ensure that communities can take control of those facilities in an empowered way and run them for the benefit of the community. There is lots of work going on on that, and I am happy to provide more information on it.

The Convener: That is great. David Torrance also has questions on the active Scotland delivery plan.

David Torrance (Kirkcaldy) (SNP): Physical activity and access to exercise are really important in tackling obesity, poor mental health, loneliness and medical conditions. There are many key stakeholders. How is the Scottish Government engaging with sporting bodies, whose experience could help you to deliver the plan?

Maree Todd: We already work closely with sports governing bodies and a whole load of stakeholders. Sportscotland is the organisation that does much of the work on the ground. I am a huge rugby fan. We were unable to go to rugby matches because of the pandemic—in fact, Sunday was the first time since the pandemic started that there has been a full-capacity crowd at Murrayfield. There have been challenges in delivering sport, from huge elite-level events down to making grass-roots sport Covid safe. We have had to consider what rules and regulations need to be in place to ensure that Covid transmission does not occur while people are playing sport. We have worked incredibly closely with sports bodies over the past 20 months and I am absolutely sure that that will help us.

You are quite right that sport has the power to reach people and to motivate and inspire them in a way that me telling them stuff does not. We are pretty keen to use that power to tackle all the big problems. For example, over the course of the 26th United Nations climate change conference of the parties—COP26—I will have a couple of interesting meetings and collaborations about how we can use sport to tackle climate change.

Carol Mochan: I have heard numerous reports that, although good school facilities are available, it is difficult for communities to access them. Have you or do you intend to look at how communities can access the excellent facilities that are already there?

Maree Todd: We have work going on in relation to that issue and, again, I can write to you with more details. I know that there are a couple of pilot schemes in Dundee around ensuring that children have access to the school estate out of school hours for not only sport, but creative and cultural activities. We recognise how important that is and that schools are a public space.

It is interesting that you should ask about sports facilities in schools. I recently took part in a four-nations sports cabinet meeting and found out that the United Kingdom sports minister is working on the issue. At the end of that meeting, I asked for more details from my officials about the situation in Scotland and I will be more than happy to share that with you when I get it.

The Convener: We will move to questions on the proposed Good Food Nation (Scotland) Bill and Food Standards Scotland.

Emma Harper: The bill was laid on 7 October and will be scrutinised by the Rural Affairs, Islands and Natural Environment Committee. However, given that nutritious diet and access to healthy food are integral to our public health agenda, this committee is interested in it, too. How will the Government work to ensure that public health priorities are integral to the bill?

Maree Todd: As I have said repeatedly today, the solutions to some of the challenges that we face in terms of, for example, health inequalities do not all lie within my portfolio and, in order to solve them, we will have to rise to the challenge of breaking down silos to work together across portfolios. We need to ensure that there is a

cohesiveness across the piece so that we can deliver our priorities. I will be working hard to ensure that public health priorities are reflected in the bill. One of the basic issues is tackling food insecurity. It is devastating that, in the sixth-richest country in the world, we have people who are food insecure, so we will be focusing on that, as well as on the broader issues of nutrition.

Emma Harper: I know that the bill is a framework bill and is, therefore, not as prescriptive as other types of legislation. How will the Government work with local authorities and other stakeholders to ensure that the bill has the ability to guide everyone to take the good food nation plan forward?

Maree Todd: Michael Kellet might want to come in here, because it is not my bill, so my level of detailed understanding of the bill is perhaps not what it would be if it were.

I understand that there are duties on local authorities and that there will be, for example, a requirement to procure locally as well as other measures that will deliver health benefits to the population.

Michael, can you help me out here?

Michael Kellet: I will do my best, minister. Again, it might be useful for us to write to the committee with more information. I can say that colleagues in my directorate who have responsibility for leading on challenges around obesity and diet work closely with colleagues who are working on the bill and colleagues in Food Standards Scotland. We see the bill as an important vehicle to deliver the agenda around better diet and health inequalities.

Emma Harper: I have a quick final supplementary question. Our notes have a question about food banks. I read the statistic that we have more than 91 independent food banks in Scotland, and we know that food-bank use has increased due to Covid. It is worrying that the issue persists. Will the bill have a strategy to end the need for food banks?

Maree Todd: Absolutely. As I said, it is a devastating fact that there is food insecurity in a country that is as rich as ours. Work is going on across the Government. For example, we are introducing human rights legislation, which I think will ensure that people have access to good-quality food.

There are food banks in every community. Earlier, I spoke about the impact of welfare reform. In the 11 years since the Conservative-Liberal Democrat coalition came in at Westminster in 2010, we have seen a rise in the number of food banks, and there is lots of evidence that food insecurity has increased since that time due to the impact on welfare reform.

We are determined to tackle food insecurity. We recognise that lots of communities are providing food in different ways, with dignity at their heart, such as by having community larders rather than a food bank. However, essentially, behind it all is the devastating fact that there are more people with food insecurity than there ever were, and we need to put in place policies that will prevent that from being the case.

The Convener: We will have one more question on the matter, and then we have to move on to discuss palliative care, because a significant number of members want to discuss it with the minister.

We have a question from Sandesh Gulhane on the good food nation and Food Standards Scotland.

Sandesh Gulhane (Glasgow) (Con): Good morning, minister.

My question is in two parts, and is about ensuring that children get good-quality food in school. What standards are in place to ensure that children get good-quality food and that there is not an unhealthy option that is always taken up? What is being done to ensure that the areas around schools maintain healthy eating areas?

Maree Todd: On the quality of food in schools, I can send you further information about the food standards in schools and the fact that we have increased our offer of access to school meals for primary school children and made it all year round.

On tackling the food environment, we need to tackle the issue as a whole. In Scotland, we have an obesogenic environment, in which it is very easy to eat badly and exercise little. That applies to children as much as it does to everyone else. I can see the logic of controlling the environment around schools, and I am interested in looking into that, but children live everywhere. Children navigate life not only around school but throughout our communities. They are also exposed to advertising—for example, at sports events—which influences their behaviours. Therefore, we need to think more broadly than just the environment around the school. You are right, and it is one aspect that we will look at, but consideration of the issue needs to be bigger and bolder than that.

The Convener: We will move on to talk about palliative care, which a number of my colleagues want to come in on.

Evelyn Tweed: What support will the Scottish Government give to hospices for adults to support the best end-of life care for everyone?

Maree Todd: Again, it is impossible to disentangle where we are now from the experience that we have had over the past 20 months. Over the past 20 months, more people than ever before have been dying at home. In some ways, you might consider that to be a positive thing, because if you ask people where they want to die, they largely want to die at home. However, we need to ensure that support systems are in place and that everyone who requires palliative care can access it.

We need to ensure that the offer of palliative care is available to people, whatever condition they are suffering from. There are concerns that palliative care is more focused on conditions such as cancer and is less available for conditions such as heart failure. We need to ensure that palliative care is accessible across the board.

10:15

We also need to ensure that palliative care is accessible across our communities. As with every kind of care, there is a health inequality aspect. People from richer areas are more able to access palliative care. That will be a focus for us all.

We need to ingrain palliative care. We need to be having conversations about death and dying, and to be looking at advance directives and advance planning. Those things need to be handled extremely sensitively, and people need to be well informed and supported to make their own decisions. We need to have more conversations about that. A great deal of work is going on, across the board, on palliative care.

Sue Webber: You spoke to us about the importance of the 20-minute neighbourhood, which involves easy access to things within walking distance. You made the statement that centralising services far away is not helpful. You have also mentioned, and are aware of, the importance of good-quality end-of-life palliative care close to the heart of communities. Will the Government therefore encourage health boards to do everything that they can to preserve and expand the services that are in local communities?

On a specific local issue, my colleague Craig Hoy and I were at the "Hands around the Edington" rally on Sunday. Right now, that issue is a very serious one for the community in North Berwick. We have already said that care should be within communities. Will you now reach out to NHS Lothian and urgently reverse the closure of the in-patient palliative beds at the Edington hospital?

Maree Todd: I am more than happy to look into that for you. I would be pleased if you would write to me on that specific issue, and I will be happy to pick it up, look into it and see what I can do to help.

Time and again, we talk about people being able to access flexible and holistic patient-centred care as close to home as possible. In my part of the country, as you would expect, there has been innovation over the past 20 months in providing palliative care that might in the past have been provided in a building in a centralised place. In providing support to local people in order to provide that care at home, technology is being used as never before. Networks that have never before been available are springing up between health professionals, through the use of technology.

Obviously, I am not going to pronounce on the particular situation that you have raised, because I am not aware of all the details. However, what we want is for patients to experience high-quality end-of-life care at home or as close to home as possible.

The Convener: Other members want to come in on palliative care.

Gillian Mackay: I have a very brief supplementary question to follow up on Emma Harper's questions. What work are you doing alongside the Minister for Mental Wellbeing and Social Care to make sure that families and carers who have been bereaved are supported? In the past 18 months, grief has been very odd for many people. I am interested in what work has been done on that.

Maree Todd: Absolutely. My portfolio includes the funeral sector. I recently had a meeting with representatives of that sector, and I am in awe of the work that they have done to ensure that people can still access what are very important rituals. One of the toughest aspects of the pandemic has been in asking people to stay apart at a time when, usually, a community comes together, supports people, and reflects on and celebrates somebody's life. There have been really tough times.

Work is already going on. Certainly, when I was the Minister for Children and Young People, there was work going on to recognise the significant impact of childhood bereavement. An inspirational young woman called Denisha Killoh did a lot of work looking at what is available for children and trying to join up what is—to be honest—a patchwork so that it becomes more cohesive. We can learn from that kind of work to ensure that bereavement care for families is at the fore. More people have experienced bereavement in more difficult circumstances in the past 20 months than ever before.

Stephanie Callaghan: Orders not to attempt cardiopulmonary resuscitation—often called

DNRs, or do not resuscitate orders—have been in the news. That has created fear, because there is a feeling that some use has not been consensual. I have looked into this, I know that families instinctively want to save their loved ones and want them to have as long a life as possible, but DNRs can also prevent harm and distress. A lot of people do not understand how distressing resuscitation procedures can be. Are we looking at the public message about people having kind, compassionate and comfortable deaths, rather focusing on the use of DNRs, which involves a fear factor? What are we doing to improve that?

Maree Todd: There is good work in the palliative care community to raise the profile of those conversations. There is still a taboo around death. One of the challenges is that there is still discomfort and we still use lots of euphemisms to talk about death. People are not exposed to death as they might have been a generation ago. Most people die in hospital. Our society is distanced from death, although death and taxes are the only sure things in life.

It is important to have those conversations. There is a campaign happening in the next couple of weeks—I will tweet about it if I can find more information—that will talk about opening up those conversations, which should not be reserved for the end of life. We should be talking about death and about our wishes.

A lot of that happens when we discuss organ donation. We have tried hard to ensure that families talk about organ donation long before they are in that situation. As part of organ donation week this week, we heard the story of an amazing woman whose husband died suddenly in difficult circumstances. Because they had had that conversation, she knew, even in the moment of crisis, that she wanted his organs to be donated. That act helped many families, which has in turn helped her bereavement process.

It is important to have the conversations early and to be open and honest. It will take the fear factor out of death and will ensure that people are able to access the services that will support them as they approach death. It also makes life easier for the family, who will not be left wondering whether they did the right thing. I am all for increasing such conversations and I will do whatever I can in my role to support them.

Sandesh Gulhane: When I was doing my GP shift yesterday, I had a conversation about DNACPR, whci stands for “do not attempt cardiopulmonary resuscitation”. That is not one conversation; it is the start of a conversation that has to be gone back to on multiple occasions.

I visited the Prince and Princess of Wales Hospice, which is providing amazing care. It even has beds for young adults. Because that is an independent hospice, a patient who wants respite but whose funding is being controlled by the council is not able to access care at that hospice. They can only go to a hospice that is part of a big chain and they cannot access the amazing care that that hospice provides.

Would you be able to look at that, to stop that from happening and to allow even people whose councils control their respite funding to be able to choose where they go for respite care?

Maree Todd: The best thing that you can do is to write to me and explain that particular problem. I am more than happy to find out what the situation is and come back to you. I am not aware of people being unable to access hospice care when they need it, so I want to know the details of that before I give you advice on it.

The Convener: This is a session on top-level priorities, so we will move on. Members have questions on the issues around clean air.

Gillian Mackay: Air pollution monitoring will be key to identifying problem areas. Has the Scottish Government considered implementing a system of health alerts, which are informed by air pollution monitoring, to people with lung conditions, so that they know which areas to avoid?

Maree Todd: Again, I will look into that. There is a national system of health alerts. Over the course of my lifetime, television weather forecasters have started to give warnings at times of low air quality, which people with lung conditions pay a great deal of attention to. There is a recognition that that is important for conditions such as asthma—an asthma epidemic in London many years ago prompted that change in practice. The challenge is communicating the information to the people who need to know, but you are right that we have systems in place. People are now significantly more health literate and look after their conditions in a way that they have not done before, so there might be an opportunity to communicate that risk in a different way, rather than broadcasting it on television.

Emma Harper: I will be quick, because I am conscious of time. I am interested in an update on the respiratory care action plan and how that will address air quality issues. I ask because I am the co-convener of the cross-party group on lung health.

Maree Todd: Again, I have already mentioned how important it is for us to tackle that. For example, active transport is a solution to tackling climate change. Getting cars off the road will make spaces more comfortable for people and also reduce particulate pollution, so it is a win-win situation. Investing in active transport

infrastructure is a really important priority for this Government.

Recently, I was at a World Health Organization panel event, and I presented with the deputy mayor of Paris, where the authorities have done remarkable work in a very short period. The population density of Paris means that many people live in a small space, so it is difficult for people to have enough space to navigate, and the city also had a significant pollution problem. The pandemic offered the authorities an opportunity to put in place infrastructure that transformed the way that people live, and that approach has been hugely popular.

During the course of the pandemic, there have been some controversies associated with the spaces for people programme in Scotland, and some of the infrastructure—which was put in to make the environment easier for active transport—has been removed. We need to work with communities to find out what works for them, but we absolutely need to increase the level of active transport, because it will tackle climate change and make us healthier—because we will be more physically active—and because we need to reduce the level of particulate pollution that people are exposed to. All three of those targets are incontrovertible.

The Convener: Minister, we are coming towards the end of the allotted time for our session, so can we have another 10 minutes of your time? Paul O'Kane has a question on the clean air aspect.

Maree Todd: That is fine.

Paul O'Kane (West Scotland) (Lab): Thank you, minister. I will follow on from that point. We are meeting during COP26, and the climate change aspect of clean air is linked to the public health duty. The "Clear the air" report from Asthma UK and the British Lung Foundation highlighted the specific impact that poor air quality has on low income communities. I am keen to get a sense of what we are doing within the strategy to target those low income communities and areas of multiple deprivation, with regard to issues such as active travel and active transport.

10:30

Maree Todd: Right across the board, in everything that we do, we look at things through an inequality lens. With any policy that we introduce, we make sure that we look at things in that way and that we specifically target those people who suffer the greatest health inequalities.

We are doing a number of simple things. For example, we had a manifesto pledge to ensure that children all over Scotland had access to a bike, and we now have 10 pilots going on in different parts of Scotland. The barriers to bike ownership are different in different communities. We are putting in place pilots that make bikes accessible to people in every part of our community. The challenge is not just with being able to afford a bike; it is also necessary to have somewhere to store a bike. Someone who lives in a city-centre flat might not have anywhere to put their bike. There is also the challenge of a lack of bike infrastructure. Most people would think twice about letting their children out on busy city roads. Cycle lanes need to be provided so that they can cycle safely. The ability to repair bikes is also required in communities. The challenges are multiple, but the pilots will help us to solve the problems.

We thought about having a specific pilot for people who need accessible bikes, but we decided that it was more important to ensure that accessible bikes are available everywhere. A thread that runs through our work is ensuring that there is provision for those people for whom bike ownership is really challenging, perhaps because they have a disability and cannot use a standard bike. I think that the pilots will give us a great deal of information that will help us to transform the landscape over the course of the parliamentary session.

The Convener: I will go to Sandesh Gulhane for a final question on cleaner air, after which I will come back to Paul O'Kane, who has some questions on the theme of indirect health harms from Covid-19.

Sandesh Gulhane: I am glad to hear that one of the aims is to get cars off the road. One of the big problems is with commuting to work, because the traffic means that everyone just sits there.

I will use the Queen Elizabeth university hospital as an example of a greater issue that exists around Scotland. Public transport to get people to the hospital is not good enough. There are no cycle lanes for people to use to get to the hospital, and there are no shower facilities for people who cycle in.

How can we ensure that other places around Scotland have the infrastructure that is required to stop people driving into work? How can we help big hospitals such as the Queen Elizabeth university hospital?

Maree Todd: You are absolutely right. One of the challenges is that such considerations have to be taken account of at the design stage. We must think about how we will encourage the use of active transport when we plan the infrastructure. As I said, there are more barriers than the barrier to bike ownership.

You arrived late, so I think that you missed the part of the discussion about using our NHS facilities as anchor institutions. That is partly about procurement and spending money in local communities, but it is also partly about ensuring that healthcare settings are as healthy as they can be and that people who work there can use active transport to access them, instead of having to take their cars. It is really important that we ensure that that is the case.

Time and time again, when I speak to people who are interested in sport and physical activity, I explain that one of the significant challenges of my role is that I am regularly preaching to the converted. I speak to people who already recognise the importance of sport and physical activity; what I need to do is speak to people who do not recognise that. I need to speak to the people in councils and the NHS who make decisions on the spending of public money, as well as the people who make decisions about planning infrastructure. I need to speak to people across the board who are involved in making such decisions so that we ensure that we have a cohesive approach, that we think about 20-minute neighbourhoods and that we consider the need for our NHS staff to be healthy in going to and from work.

The Convener: That is another example of how public health reaches into all areas of life.

Sandesh Gulhane: Convener, I should just place on the record that, earlier, I was listening to the meeting online, so I was able to hear the minister.

The Convener: That is good.

To round things off, Paul O'Kane has questions on the indirect health harms of Covid-19. Minister, thank you for staying on for a little longer.

Paul O'Kane: Yes, thank you for giving us more time, minister. We have had a meaningful discussion about public health and the huge amount that needs to be done. The narrative of a public health Parliament has permeated the discussion.

We are dealing with Covid-19 and its far-reaching impact. In the next part of the meeting, we will hear about the pressures on our NHS as we approach the winter. How can we address the wider public health challenges, which have been exacerbated by the pandemic, while dealing with the huge challenge of remobilisation and getting the delivery of acute services, in particular, back to the right level?

Maree Todd: The first thing to say is that the pandemic is not over. Each and every one of us must continue to take steps to reduce transmission. I am talking about the basic mitigations: wearing a mask, keeping your distance and not mixing indoors where possible, all of which are important. It is also really important to get your vaccination. A massive vaccination programme is going on, and the level of vaccination that we are managing to achieve in this country is remarkable. As I think that I said, about 9.5 million doses have gone into people's arms since the start of the programme in December. The requirement for vaccination during the autumn programme this year—the first tranche—was 8 million doses, to cover two doses for the eligible population; now we have to give 7.5 million doses in half the time, because we are combining flu vaccination with Covid boosters. It is a phenomenal task, and getting people vaccinated is a really important step.

You are absolutely right to say that the healthcare system faces the most challenging period in its 73 years, as I have heard the cabinet secretary and others say. We still face a global pandemic. There are about 800 people in hospital with Covid at the moment and many intensive care units have a number of Covid patients. That makes it difficult to restart the NHS, because many people need a period in an intensive care unit after a routine operation. We are in extremely challenging times, with pent-up demand and patients presenting with a level of acuity, because people have not accessed healthcare in the usual way over the past couple of years. All that makes for an exceptionally challenging situation.

A great deal of work is going on to improve the situation. Just last week, you will have seen the announcement about A and E and the use of a multidisciplinary team to ensure that people get the right care at the right time and that A and E sees only the people who need to present and be treated there. Over the past few days, I was briefed about some excellent work that is going on in NHS Greater Glasgow and Clyde to improve flow through hospitals. We recognise how significant that approach could be if it were taken throughout the country. We are very close to the issues and challenges that people on the ground are facing. The situation is very dynamic, but we are finding ways to improve it as we go along.

The period ahead will be difficult—there is absolutely no doubt about that. We anticipate a significantly more severe burden of disease when it comes to flu, given that immunity has dropped because we did not experience a flu season last year. There are massive challenges, to which we must rise, and we are across those challenges in a dynamic way and taking steps to face them over the next few months.

The Convener: We must end there. I thank my colleagues for being succinct and I thank you, minister, for giving us some extra time. In the next

part of the meeting we will talk about winter planning and preparedness.

10:39

Meeting suspended.

10:46

On resuming—

Seasonal Planning and Preparedness

The Convener: Welcome back. Our third agenda item is an evidence session on seasonal planning and preparedness. There seems to be an echo in the room; can we get that sorted out, if it is not just in my head? [*Laughter*.] I think that it has been sorted. Thank you very much.

I welcome Dr John Thomson, who is the vice-president in Scotland of the Royal College of Emergency Medicine; Dr Andrew Buist, who is chair of the British Medical Association's general practitioner committee; Colin Poolman, who is interim director of the Royal College of Nursing; Sharon Wiener-Ogilvie, who is the podiatry service lead for NHS Borders and is representing the Allied Health Professions Federation Scotland; Annie Gunner Logan, who is the chief executive of the Coalition of Care and Support Providers in Scotland; and John Mooney, who is the head of social care at Unison. All are joining us remotely. I thank you very much for hanging on while we had that extended session with the minister.

I will ask about one of the things that struck me in all your written submissions, when you talk about winter preparedness. I suppose that we are in winter now, so it is all starting to kick off. We have heard all the concerns about the ability of the NHS and social care to get us through the winter in what is—as we have heard—probably one of the most challenging times in the life of the country and in health and social care. You have all pointed to one thing. It is a thread that runs through every submission: the number of staff vacancies, and the issues around recruitment that you are all having, in getting your services up and running at full capacity to meet—or to try to meet—demand.

I will go round the witnesses to get a sense of what the difficulties are in filling vacancies, and to ask where you think action could be taken to assist in that. I will come to each of you in turn, with John Thomson being first.

Dr John Thomson (Royal College of Emergency Medicine): Thank you and good morning, convener. Certainly, there are significant issues in emergency medicine throughout the country when it comes to vacancies—not just medical vacancies but, as I am sure my colleague from the Royal College of Nursing will also state, nursing vacancies.

The training scheme for doctors in emergency medicine is quite prescriptive, and the numbers are determined nationally. In effect, they are based on the predicted numbers of consultants

that will be required six years from when those individuals finish their training. Essentially, the numbers are significantly out of date.

This year, for the first time ever, the RCEM undertook a workforce census. The information that it provided was really quite revealing, and we have included it in our written submission.

The ideal consultant-to-patient ratio is one consultant for every 4,000 patients. Currently in Scotland, we have one consultant for every 6,450 patients. I acknowledge that there has been a significant increase in the number of consultants in the past few years, but we are still significantly understaffed. The college has estimated that Scotland is still approximately 130 whole-time-equivalent consultants short of what would allow us to safely staff our emergency departments with senior decision makers.

Dr Andrew Buist (British Medical Association): Unlike in emergency medicine, general practice has not had an extension of our numbers in recent years. A workforce survey that was published recently showed that our numbers have flatlined. They are no higher now than they were in 2013. We have an agreed policy to expand GP numbers by 800 by 2027, but we have not made any progress towards that.

Last month, we carried out a survey that showed that there were about 225 whole-time-equivalent GP vacancies across Scotland. The key thing is to recruit and retain more GPs. I am worried that we are losing GPs and that the work intensity has risen enormously throughout the Covid pandemic. The survey, which we published on Friday, showed that, in one week in October, we provided more than 500,000 appointments in general practice in Scotland: one in every 10 people in Scotland was assessed by a clinician in general practice in one week.

There is an enormous strain on the workforce just now. Many of my colleagues are extremely tired and their morale is down. I am worried that they are burning out. In such circumstances, individuals might decide that they are, for their wellbeing, going to cut down what they do, or they might decide to leave the profession.

We have a serious situation with general practice, which is so fundamental to our NHS—it is the "foundation of the NHS", as the previous cabinet secretary said. We need to retain and recruit more GPs.

The Convener: I want to go back to what Dr Buist said about morale. An issue that has been brought up with me in speaking to GPs in my constituency is how demoralised they feel about the perception of them in the media. They feel that they are constantly fighting against the rhetoric that GPs need to "get back to work". They have never stopped working throughout the pandemic. I am interested to know your thoughts on that. That seems to be a narrative that is making things a lot worse for the morale of GPs.

Dr Buist: Indeed, it has done that. Most of that rhetoric has come from England, but there has been some in Scotland. What newspapers print down south creeps up here—the public see it and some members of the public believe it. In fact, general practice has been very much on the front line of the fight against Covid since March last year. That is not just in practices but in out-of-hours centres and Covid assessment centres, which have been very important in keeping people who have Covid symptoms away from general practice, so that we can see patients who have all the other problems that they come to general practice with, and so that we can reduce the risk of infection transmission.

What we have seen in the media and, sadly, what some politicians have said about what we have been doing is, and has been, demoralising.

The Convener: Colin Poolman will give the perspective of the RCN.

Colin Poolman (Royal College of Nursing): Thank you for the invitation to address the committee.

Our members are telling us that they have never been under greater pressure and—[*Inaudible*.]—the sustained levels of stress and pressure in the workforce over the past two years, they are exhausted and worn out.

That brings me to the significant issue for us, which is retention of the current workforce. Every day, when we survey people who are looking to leave the profession, we hear from nurses about the sustained pressure that they and their colleagues are under and the difficulties that they face in delivery of day-to-day services.

Our difficulty is that we do not have thousands of people waiting to be employed. Therefore, we have to think about how we plan our student nursing training in the medium to long term, and about how we can get a better supply of people. We need to be up front about the fact that the workforce planning measures that we have all had in place have not been sufficient to meet what we now require. We need to build on our workforce planning and to plan for what we need instead of what we can afford. In the past, we made the mistake of planning for what we could afford and not for what we needed. That covers the recruitment element.

The other element is retention. As I said, every day, people who are leaving the profession tell us about the demands that are placed on them incessantly. Because they can see no change in

the situation, they are making that decision for the good of their own health and wellbeing. We need to think about what we can do to support people and about how we can, through things such as offering flexible employment patterns, retain those individuals in order to ensure that we have in place the right numbers.

People say to me that there have never been more nurses in the NHS than there are at the moment. My response is that there have never been more nurse vacancies in the NHS. We need to do as much as possible to address retention, which is just as important as recruitment. Every person who leaves represents a person whom we need to recruit. That is just logic.

The pressures make the situation extremely difficult. We need to work on that with all stakeholders, including the public, because we need to be up front with them. Andrew Buist just talked about that in relation to GPs. We are hearing accounts of nurses being abused because, quite frankly, of the messages that are being put out about what is possible and what is not possible. We, the media and yourselves need to do everything that we can to be open and honest with the public.

The Convener: I can see members all nodding at that. A couple of my colleagues will come back to patient frustration and expectation later.

Sharon Wiener-Ogilvie (Allied Health Professions Federation Scotland): Thank you for inviting the Allied Health Professions Federation Scotland to speak to the committee. We represent 12 allied health professional bodies, including those for physiotherapists, occupational therapists, dieticians, speech and language therapists, podiatrists, radiographers and so on. I will not name them all; that was just to give you some examples.

As the other witnesses' professions are, we are experiencing significant staffing issues in our workforce and are encountering difficulties in filling vacancies. There are key pressures in relation to radiographers and podiatrists at the moment, but there are vacancies in all the professions that we represent. That affects our ability to help people to stay safely at home and to self-manage at home in order to avoid hospital admission, and it prevents us from supporting the preventative health agenda.

The question was about what is causing the difficulties to be exacerbated. There are two main issues. One is that, in Scotland, we currently do not have a sustainable education model to support workforce development for allied health professionals. We are very much at the mercy of the higher education institutions with regard to how many places are made available. The number depends very much on market pressure—that is, what students want to study. We really need to move to a more sustainable model whereby, for example, the Scottish Government, through discussions with higher education institutions, commissions places across all professions.

The second thing that exacerbates problems in our ability to recruit and retain staff is short-term funding and the lateness of funding getting to boards. A lot of the time, we receive funding around autumn time and are expected to spend that money by March and deliver outcomes. That exacerbates existing challenges that we have in recruitment, because it is very difficult to fill fixed-term posts.

11:00

We need to take a more risk-based approach to finance and recruitment, because getting the money now from the Scottish Government will make it difficult for us to have an impact on the pressures this winter.

The Convener: Thank you. I turn to Annie Gunner Logan.

Annie Gunner Logan (Coalition of Care and support Providers in Scotland): Thank you for inviting me here today and for considering social care as part of the session. We are absolutely delighted that social care now features in the title of the committee—for the first time since 1999. It feels like we are properly included now, so thank you for that.

I will start with a positive. Third sector social care organisations in our membership employ about 43,000 people and have all been operating at high volumes of work and delivering high quality care throughout the pandemic. By and large, they have been able to maintain services for the people whom they support. As others have said, the sector does not need to be remobilised, because we never stopped.

However, staff recruitment and retention issues for social care providers are now acute and are worsening. The staff whom we have are brilliant, but they are exhausted; they are leaving and are not coming back. Recruitment has always been an issue in social care, but we have never referred to it as a crisis before now.

We first raised major issues in recruitment in the summer of 2021, when we conducted a survey of our members. The outlying findings from it are in the written submission to the committee. What are we doing about it? We are not just sitting around; a lot of activity is going on. Providers are constantly advertising posts, and many are taking advantage of the myjobscotland portal, which we are now able to access free of charge, which is

brilliant. Members are looking at ways to increase recruitment, including local community job fairs, events at local supermarkets and shopping centres, use of social media and use of local newspapers, but all that requires a lot of resources, including time spent planning and the costs of advertising.

A national marketing campaign for social care, which began yesterday and will run into mid-January, is really welcome. However, there remains a lack of confidence among providers about how successful the campaign will be, because it is about awareness raising, and there is a very competitive job market out there.

On that note, retention remains a significant issue, and our members indicate that that is primarily due to burnout, stress, increased workload because of staffing shortages, and better pay and terms and conditions elsewhere, which is particularly true in remote areas, where retail and hospitality offer much better pay.

The convener asked what we would like to see, and I have a list. The next phase of the campaign needs to focus on recruitment and to tell people, "There are jobs available now—here they are", rather than just generally raising awareness of the importance of social care, important though that is.

More national and sector collaboration is needed in order that we understand and address the specific needs of remote and rural providers.

We need increased consideration of retention, with national activity around that, in order to understand why people come into social care, why they stay and what needs to change to get them to stay longer.

In addition, organisations such as ours need to be included in more of the national and strategic discussions around that. I said in the submission that we were part of a rapid action group that was convened in the summer to look at recruitment. That group has been stood down, and we do not know where the discussion has gone. Wherever it has gone, we are not part of it, and that is serious.

Fundamentally, in social care what we need is much faster progress towards fair work. There is a lot of activity going on; I am part of that. We are looking at pay, terms and conditions and so on, and there is a great deal of promise. The committee will have seen the proposals for the national care service and what they say about fair work. My worry is that that is still years away. We are talking about this winter, but the national care service will not be here for a long time, so we need to do something much more immediately.

We also need a complete overhaul of the way in which social care is commissioned. In Audit Scotland's submission to the national care service consultation, the Auditor General, no less, said that current funding and commissioning arrangements make it virtually impossible for employers to deliver fair work. It is not just me who is saying that—the Auditor General is saying it. However, the system persists with short-term and price-driven competitive tendering, and it is killing the sector and recruitment.

Finally, we need a reappraisal of the value of social care. With the greatest respect to my fellow witnesses this morning, I say that our system is very NHS-centric. To the extent that social care is considered to be valuable, its value is often assessed according to how far it relieves, or indeed contributes to, pressure on the NHS. However, social care is a public service in its own right, and it has a value of its own that is entirely distinct from the NHS and requires a distinct skill set and approach. That needs to be emphasised much more if we are going to attract people in. Therefore, there are short-term, medium-term and long-term approaches to recruitment.

The Convener: That is helpful, and it is a springboard for my colleagues to ask supplementary questions.

John Mooney (Unison): I am delighted to be here today to speak on behalf of Unison members who arrange, support and provide social care across Scotland.

As members can see from my written submission, Unison Scotland has finished a survey of thousands of members in social care. There are some really alarming statistics around where they are headed this winter. In particular, I draw attention to the fact that 35 per cent of respondents are already considering leaving or are actively trying to leave the sector. A further 53 per cent are speaking about the fact that they urgently need a break. That should draw members' gaze to the issues that we are facing.

With regard to the national care service, there are loads of proposals that will be very helpful to social care but, quite frankly, that is years away. We need urgent radical action. I will comment on three areas.

First, we need to boost recruitment. In order to do that, working in social care needs to be made an attractive proposition. That requires the organisations involved to fish in a different pond for people who are seeking jobs in other areas. To put it bluntly, the proposals to increase pay by 52p do not address the fact that those jobseekers are also looking for jobs in retail. We need something far more radical than that. With regard to recruitment, from providers that we deal with, we are sitting at a staffing level of around 90 per cent to 94 per cent, which is really concerning. We hear weekly reports that people are not attending their

interviews. Recruitment is therefore an urgent high-priority issue.

The major issue of staff sickness follows on from that. The staffing level drops from 90 per cent to 94 per cent to around 82 per cent to 84 per cent when we factor in staff sickness. The reason for that is that, across Scotland, our members have not stopped since the beginning of the pandemic, and the demands just get greater and greater every day. They have constant shifts, and there is no work-life balance in social care. They are being asked to work to rotas that people in other sectors would not even begin to consider, to be honest. They give up family time, and they are pressured into picking up those shifts. That needs to change.

That takes us on to the issue of retention. We are just coming through the Covid-19 pandemic, and we are now facing a burn-out pandemic. We already have investigations into why there were so many Covid deaths. I am really concerned that, at the end of this winter, we are going to be investigating deaths that have resulted from staff shortages. I cannot impress upon you enough the messages coming from our members that they need help. They need more staff, they need more respect at work, they need to be valued, and they need fair pay and other measures. Those are all needed to keep people in the system.

As members will see, our submission contains a number of suggestions—to be honest, we could make a number more. The Scottish Government very helpfully brought in the social care staff support fund, which helps with sick pay to cover Covid-related absences, but the reality is that many social care workers who are off sick for other reasons do not get sick pay at all. It is therefore easy to see why people are choosing to move to other areas in which there is less stress and the pay is the same.

The Convener: Colleagues will pick up on some of those issues and others, but I ask them to make a note of which witness they would like to direct their question to. We will not be able to go round absolutely everyone for every question.

Before I hand over to David Torrance, John Thomson wanted to come back in briefly.

Dr Thomson: I will be brief, convener. I just wanted to echo some of the comments that colleagues have made about demoralisation in the workforce, but I also note that, with regard to workforce planning and what might be called unknown factors in emergency medicine, one in five colleagues has stated that they plan to take early retirement in the next five years and one in two colleagues has stated that they plan to reduce their hours and work less than full time or, if they are already working less than that, to reduce their hours even further. As those factors are not being mitigated in workforce planning, we will be moving to an even greater crisis with a reduced workforce as a result of the pressure that colleagues are facing.

The Convener: David Torrance has some questions on that very issue.

David Torrance: Good morning, panel. With regard to staff shortages in the NHS and the social care sector, what impact has Brexit had on your ability to recruit internationally?

The Convener: I guess that we will want to hear from a couple of different disciplines. Perhaps the Royal College of Emergency Medicine representative can respond first, followed by the RCN and GPs representatives.

Dr Thomson: I am not aware that Brexit has had any significant effect. We tend to have full recruitment at the start of training schemes in emergency medicine although, unfortunately, we lose colleagues along the way for a variety of reasons. Those gaps, which become apparent further down the line and only several years after those colleagues start their training, are very difficult to fill, because people with similar experience who are not already working in the specialty simply do not exist. We therefore have to have multiple rotas at many different levels with significant gaps. However, we do not struggle to recruit to the specialty in the first instance.

The Convener: Mr Poolman, have Brexit and immigration caused you any issues?

Colin Poolman: There has been a reduction in the number of individuals coming from European countries under the Nursing and Midwifery Council register, but that is a difficult issue to assess truly. After all, we have been dealing with the pandemic. Thankfully, we have not had huge numbers of people who have been recruited from the European Union leaving but, given the figures that have been reported, I think that the issue is causing difficulty in social care. Individuals who came to this country to work in social care have gone back, while individuals from the European Union have not continued to be recruited.

Has that had an impact? There has been no assessment that would allow me to give you the exact numbers, but there is no doubt that that, like all the other difficulties, has contributed to the situation.

The Convener: Perhaps Annie Gunner Logan can give us a social care perspective on that.

Annie Gunner Logan: With Brexit, it kind of depends on where you look. For example, in private sector care homes, which have quite a high proportion of non-UK-national workers, there has been an on-going campaign to get people to

apply to the EU settlement scheme to ensure that they can stay.

For us, one of the biggest issues has been that the Migration Advisory Committee still regards social care as an unskilled area of work. Apart from that being a bit offensive to those of us who are involved in it, that does not help here, because we cannot recruit internationally. We have had some conversations with the minister about that, and we are involved in some of the initiatives to tackle that.

11:15

If you were looking for a social care perspective on that, you would probably want to seek one from Scottish Care, which is the organisation that represents care homes specifically. It could give you chapter and verse on that.

The Convener: I will come back to the BMA to round this off. I invite Dr Buist to address issues around Brexit and immigration.

Dr Buist: Brexit has not significantly impacted on the majority of general practices. Most of our—[*Inaudible*.]—staff—doctors and nurses—are from Scotland or the UK originally. That is one thing, at least, that has not impacted on us.

Paul O'Kane: It is clear that a range of factors have contributed to the challenges around retention. Brexit is often cited as the key issue.

To pick up on what Annie Gunner Logan said, what mitigation work was done by the Scottish Government for care providers prior to Brexit? Was a detailed piece of work done to tackle what were perceived to be the challenges around staffing as a result of Brexit?

Annie Gunner Logan: Yes, there was some specific work around Brexit and social care. We were part of the working group, as were our colleagues in Scottish Care. Indeed, it was a much bigger issue for them.

We had a sweep of our third sector social care members on the proportion of EU nationals who were working in social care services in the third sector. That proportion was actually quite low, at about 4 per cent to 6 per cent. However, there are exceptions to that. I specifically cite Camphill Scotland, which has a very positive and strong approach to international recruitment. The proportion was more like 40 per cent for it, but it has to be said that that was a bit of an outlier.

There was a lot of work and preparation, and that work is still going on. For our membership, that is not top of the list of concerns. Scottish Care could give you much more information on that. Its survey of its own members showed that the proportion of EU nationals working in social care and in care homes in particular was very much higher.

Paul O'Kane: I wonder if I might pivot on to a point that Colin Poolman raised. Everyone has spoken this morning about the challenges in retention. It is evidently a huge challenge to keep people in the system and to support people to remain in it. I am keen to understand from Colin Poolman whether he feels that the Scottish Government's seasonal planning—the winter plan—has done much to support retention, particularly in nursing.

Colin Poolman: The additional investment in support—whether psychological support or other types of support—has, of course, been fully welcome. It is not great that it has taken a pandemic before further investment has been made to support staff, but it is there, and that is really helpful.

For us, the issue with retention comes back to numbers. It comes back to pressure and stress, and to the policies that we have put in place to support people.

We have been disappointed by the Scottish Government over the past week or so. On the one hand, we are telling our colleagues that they need to get their rest and recuperation; on the other hand, we are now offering to buy back unused annual leave. I do not think that that is a good message, and I do not think that any of my trade union colleagues think that it is.

The problem is that the pressures and the difficulties are on us, and the issue is how we get people through this. I think that there was £4 million of investment in rest areas and in making access to basic things such as food and hydration. That is welcome, and we will be keeping a close eye on that to see whether it actually makes a difference. Our colleagues tell us that they are looking for the basics—to be able to take their breaks, to get access to food and hydration, and to get the opportunity to take time off.

Although, as I have said, the money for the support services that are being set up has been really well received, one important issue is people not having the opportunity to access those services in their work time. We need to work as much as we can to ensure that people have access to the processes that we are putting in place. Last week, I was rightly challenged by a nurse who said, "It's great that all these extra facilities are going to be developed for us, but they are no good to me if I can't get off the ward, and actually it causes more frustration to see that being done."

We have a lot of issues that we need to address and work through. It is all about the sustained pressure. To go back to my point about the

workforce, every time somebody leaves, that increases the number of vacancies and the pressure on their colleagues around them. That is where the real difficulties are.

Annie Gunner Logan: I want to come in on Mr O'Kane's point about retention. One of the keys to retention is people looking after themselves and taking care of their wellbeing. We have talked about the exhaustion and burn-out that are happening. I want to mention the absolutely excellent resources that are available through the wellbeing hub, which is hosted by NHS Education for Scotland and which we have contributed to. I say that not just because I have recently joined the NES board—although I have just joined it, so I should declare that for the purposes of propriety—but because the wellbeing hub is a brilliant resource.

The challenge that a lot of social care employers and staff have in relation to that is making the time available for staff to access and use the resources. As we have heard from John Mooney and others, people are being asked to do extra shifts and to take on more responsibility, so it is challenging to carve out time to access those really good wellbeing resources.

I also want to mention the announcement in October of additional funding of £2 million for the social care workforce, which is being distributed through local areas. As of this week, only a handful of our members had heard from local authorities or health and social care partnerships about how to access that fund. The guidance on the fund was clear that it was for the whole sector and not just for public sector social care. However, one of our members has already been told, "No—this is just for local authorities; it's not for you." We need to tackle that straight away. We want streamlined and agreed processes for accessing the fund, because we find that the money is not coming to us. There needs to be some reporting back to the Scottish Government on how the money is being used.

The Convener: Thank you for that. I think that you have just reported back, so that is on the record.

A couple of our witnesses who are online want to come back in.

John Mooney: I want to come back in on the spirit of that conversation. From listening to our members, I think that the real answer is recruitment. We need to boost recruitment to take the pressure off the people who are currently delivering the services, because they are so close to burn-out. I will illustrate that with a couple of responses that we have had from members. One said:

> "Get us help soon!! It will be too late, if it's not sorted NOW!!"

Another said:

> "Help us before we get burnt out ... I'm on the edge and feel nobody cares".

Boosting recruitment is probably the best thing that we can do to help with retention.

Dr Thomson: From an emergency medicine perspective, the one thing that staff highlighted that would improve their wellbeing was improving patient flow within emergency departments. So, actually, improving the experience for our patients was the most important factor that staff highlighted in terms of their wellbeing, which is an interesting conclusion.

Sharon Wiener-Ogilvie: One possible untapped resource is the people in allied health professions who dropped off the Health and Care Professions Council register because they had to take a career pause to care for young children or parents, for example. Return-to-work schemes might be very useful in attracting some of those people back. Many health boards have very positive and flexible working policies for people. It might be helpful to try to attract people back into unfilled posts and to provide boards with support to run return-to-work training schemes.

The Convener: A few members want to talk about recruitment and pick up on issues that have been mentioned. I remind members to direct their questions to individuals, if possible.

Gillian Mackay: My question is probably for Dr Andrew Buist. The Scottish Government has made a commitment to recruit 800 GPs by 2027. Obviously, we have a problem with the number of GPs reducing their hours and working part time rather than full time. Should there be a headcount of 800, or should we focus on full-time equivalent?

Dr Buist: When the announcement was made, it was not specified whether the figure related to headcount or to full-time equivalent. Using headcount tends to deliver less—about three quarters of what would be delivered using full-time equivalent. To deliver what we need, 800 whole-time equivalent would clearly be better for Scotland. As I said earlier, I do not think that we have made any progress on the matter so far, so even having a headcount of 800 would be a positive step forward, but 800 whole-time equivalent would be better. We need to up our game in delivering the additional workforce because, four years into the process, we are largely where we were at the beginning of it.

Sandesh Gulhane: It is difficult to direct this question to one particular person. Given how desperate the nursing situation is, what would be a

realistic timeframe for recruiting people from other countries and getting them into the workforce?

The Convener: I think that that question is directed to the RCN.

Colin Poolman: International recruitment has its challenges. There are ethical considerations that we all need to think about. The Scottish Government is talking about recruiting about 200 nurses before April. If we are going to recruit internationally—as I said, we have concerns about that—we need to recruit people from countries where there are more than enough nurses so that we do not take away nurses from struggling health systems. We need to consider that.

To be fair to the boards, a number of them have already moved. One board is recruiting nurses from Hong Kong who have shown a willingness to come to the United Kingdom, and specifically to Scotland, which is excellent, so it is clear that more people are coming. Realistically, it takes about three to six months to go through all the processes and get people in. If the people can come straight on to the Nursing and Midwifery Council register, there is an adaptation programme period, which will add a few months before individuals are able to be fully active in the workforce. Recruitment obviously takes time.

It is like everything that we have talked about. We need to look at every small detail around recruitment of individuals, such as people who have left the profession coming back in. We need to look at every opportunity, and the more small numbers we add, the more it will make a significant difference. As I say, it would take months.

11:30

Carol Mochan: My question is directed to John Mooney of Unison. I absolutely care about what is happening in the social care sector, and in particular to the workers in that sector. If there was one thing that we could push the Scottish Government to do now, what would you suggest that it be?

John Mooney: At the top of our list are some kind of golden hello and a loyalty payment—some kind of lump sums. A golden hello would, I hope, attract people into the sector, and a loyalty payment would help to retain people as well as make them feel valued for the work that they have done. We have said from the start that it is great to give people recognition by clapping for them, but claps do not pay bills. Low pay throughout social care is still an issue.

In a situation where golden hello payments are being made to heavy goods vehicle drivers so that we can all have the latest iPhone, I would say to the Scottish Government that we need to look at valuing the care that our elderly relatives and disabled people—who are the most vulnerable people in our society—are receiving. I would urge that option to be considered as an absolute starter for 10, to be honest. There are many things I could mention but, as a starter, that would have an instant impact.

The Convener: I invite Annie Gunner Logan to come in on this point.

Annie Gunner Logan: On John Mooney's point, some organisations are already trying to do the golden hello and the enhanced payment, where, if someone has been doing the job for a year, they get more than the real living wage or the basic pay.

The important thing about what John Mooney is saying is that, if only some organisations but not others are able to offer that, the churn between social care organisations will be increased. If there were a national approach whereby everybody starting in social care got a golden hello and everybody in social care got an enhancement after a certain amount of time, that would need to be funded right across the board, and it would eliminate the competition between organisations that characterises social care.

The Convener: Paul O'Kane wanted to pick up on that.

Paul O'Kane: My question is for John Mooney, and Annie Gunner Logan might be able to comment as well. The point that you have made is essentially that we need to deal with pay in the care sector more broadly. John Thomson alluded to the fact that you can work in a supermarket or do bar work and earn more money than you can in social care. What is your view of trade unions, such as the GMB, Unison and others, campaigning for £15 an hour as a standard wage for care work?

John Mooney: I think that our members are absolutely worth that. To be honest with you, they are worth more than that. It is clear that their pay is currently pitched low. It just is not lifting people out of the pond that is fished in for retail staff. You also need to look at some of the plans for this winter, including putting another 1,000 staff into the NHS. The reality is that, because of the difference in pay and in terms and conditions, those people are likely to be current social care staff.

We need to look at social care in the round. I think that Annie made the point in her opening statement that social care is judged on the basis of its impact on the NHS, and that is true. We need to look at all the different roles in social care. We need to look at what is required to run social care, and to make sure that, in the worst case scenario,

it is given a fighting chance to recruit the staff that it needs.

The Convener: We are going to start drilling down on issues around some of the witnesses' specific disciplines. Some members have questions specifically about accident and emergency services, which I imagine will be directed to Dr John Thomson.

Sue Webber: I will buck the trend, convener, as my question is for Andrew Buist of the BMA, although it relates to A and E.

How does the BMA respond to claims by the Royal College of Emergency Medicine that demand in A and E is now partly attributable to reduced access to GPs and primary care?

Dr Buist: Thank you for your question—it is interesting. We are part of one big joined-up system. As I mentioned earlier, when we looked at activity in general practice last month, we saw that in one week in Scotland, more than 500,000 GP appointments were given out. In a typical week in accident and emergency, there are around 25,000 attendances, which means that in Scotland, 20 times as many people have a consultation with their GP each week. If 1 per cent of those GP attendances, or 5,000 people, go to accident and emergency instead, that represents a 20 per cent increase in A and E attendances, so you can see how the gearing affects the numbers significantly.

With regard to last week's announcement on redirection from A and E, that is a policy that I have supported. Indeed, in July last year, when we were discussing the redesign of urgent care—a policy that I do not support—I suggested to Jeane Freeman that A and E departments in Scotland should adopt the redirection policy that works in Tayside, which has helped our attendance—[*Inaudible*.]—to stay above 90 per cent consistently. She did not want to do that at the time, but the Government has now decided to go ahead with it. I support that because, as long as we explain to the public how the system works and where the right place is for people with different types of medical problems to attend, and—importantly—if we ensure that there is capacity to deal with people in the areas where they are redirected to, it is something that we should support.

However, as I said earlier, general practice is absolutely maxed out just now. We are providing more than 500,000 appointments a week, which is putting a considerable pressure on general practice. Our numbers have gone up, and our capacities are down because infection control measures mean that we are slightly less efficient. Consultations are up because there is a rising level of mental health issues, which tend to be dealt with in general practice.

There is significant back pressure from hospitals affecting general practice. When someone is referred for an operation and has to wait for more than a year, and they continue to have problems while awaiting surgery, the only place that they can go is general practice. Patients may face long waits for investigations in hospital, and again they tend to come back to general practice. We are actually performing extremely well, but it is taking its toll on us. If some of those people are overflowing into A and E, that is somewhat inevitable, given the pressures on general practice and the numbers of patients that we are seeing. As I said earlier, every week, one in 10 people in Scotland has contact with a general practitioner for a consultation. I do not know whether we can do much more than that. That is why it is desperately urgent that we start to build the GP workforce.

The Convener: I see that John Thompson also wants to come in on that question.

Dr Thomson: It is important to say that the Royal College of Emergency Medicine in Scotland has never said, at any point, that people are attending A and E because of a lack of access to primary care. I agree entirely with Dr Buist's comments about the pressures on primary care. It was a colleague in the college in England who said what Sue Webber has highlighted; it is not something that we have ever said in relation to access to primary care. It is important that that is made clear.

Sue Webber: It is clear that the traditional points of entry for access to healthcare are emergency services and general practice, and we are hearing quite loudly from both of you today that those are the services that are suffering the most right now.

The Convener: I will take a couple of quick supplementaries to Sue Webber's question from Emma Harper and Sandesh Gulhane.

Emma Harper: On NHS 24 referrals to the out-of-hours service and the impact on winter planning and capacity, is there a role for the Government, doctors and the bodies representing wider multidisciplinary teams in helping make the public aware of the solutions that need to be put in place to deal with capacity issues? Do we need to manage the public's expectations better, especially with regard to all the different ways of referring people to services, whether they be GP out-of-hours services or emergency services? Perhaps Dr Buist can respond first of all.

Dr Buist: I am delighted to come back on that question. I have been calling on the Scottish Government to put that sort of thing in place since September last year. We absolutely need to take the public with us by explaining to them what is going on. Right now, we do not have the level of

capacity that we would normally have to meet all their needs, so there has to be a degree of prioritisation, which means that, sometimes, those needs will not be met or will not be met as they would have expected. We need to explain that to the public to ensure that they understand and help us get through what we expect to be a difficult winter.

The Convener: Do you think that the public are still not, for example, using their pharmacist as much as they could be and are not aware of the services that they can get at the pharmacy and which might mean that they do not need a GP appointment? Is that still an issue?

Dr Buist: It probably is. Another door drop is planned over the next few weeks to explain to the public the available options, but I think that many people are still not fully aware of the pharmacy first option and how useful it can be for many conditions that might otherwise have to be seen in general practice.

The Convener: I see that some other panellists want to respond.

Sharon Wiener-Ogilvie: Care navigation is still very much needed, although health boards and practices in different areas have it to a greater or lesser extent. However, what we in the Allied Health Professions Federation have noticed is that more allied health professionals are acting as the point of first contact. According to a number of short-term evaluation projects that are being undertaken, those first-contact practitioners in GP practices are getting quite a positive response and are having a positive impact, so it is more a matter of care navigation and signposting patients to others apart from GPs who can meet their needs.

Sandesh Gulhane: My question is for Dr Thomson and Dr Buist. As we know, 85 per cent of all patient contact happens in primary care, and given that demand, there will be patients who will quite clearly be desperate to go to A and E instead. However, they might then be redirected from A and E back to their GPs. Is there a set of patients who are simply being passed between primary care and A and E, and if so, what can we do to stop that happening?

Dr Buist: That is clearly a risk. I have to say that I support the redirection policy, but it needs to be introduced sensitively and with a degree of flexibility by the senior clinical decision maker at the front door.

Once such a policy gets established, the public get to know that turning up at A and E with the sore back that you have had for two months will not get you seen, and in areas such as Tayside, where they have been doing this for a number of years, patients have stopped turning up at A and E and are going to their GP, as is appropriate for such problems.

However, I worry about a merry-go-round and people being passed around. That is why I am strongly against the policy that is being pursued just now on the redesign of urgent care, through which patients who would previously have attended A and E are supposed to phone 111 to get NHS 24. Sometimes, they have to wait 20 to 30 minutes to have the first call answered, and the idea is that they are maybe given an appointment time to go to A and E. That could be for someone with a cut to their leg or a broken wrist. The policy is full of flaws and will have unintended consequences, one of which is the merry-go-round that you refer to.

11:45

Stephanie Callaghan: It was good to hear from Dr Buist about Tayside, where the NHS is working together with local authorities to roll out the enhanced community model, which relates especially to older people at home. However, my question is for Annie Gunner Logan and perhaps John Mooney. Integration joint boards have done quite a bit of work on preventing admission to hospital and ensuring that people are discharged as quickly as possible, which fits with the Tayside model. What are your views on how helpful that can be? How much of that model do we need to incorporate in future?

Annie Gunner Logan: That is an interesting question for our constituency of interest. Most third sector providers support people who sometimes have very complex social care needs but who are not in and out of hospital. The issue goes back to what I said at the top of the meeting about seeing social care through the prism of the extent to which it acts as a pressure valve for the NHS, which is where I think your question is going. Most of our members support people who have learning disability and perhaps mental health issues and who are not being admitted to and discharged from hospital. They use the NHS just as you and I use it.

You are probably referring to delayed discharges for older people. An awful lot more could be made of the third sector in that regard. I recommend that you speak to organisations such as the British Red Cross, which has some fantastic home from hospital services. Those are not registered care services in the way that we conceptualise social care, but they do a huge amount, and that is with volunteers, so the staffing and recruitment issues are entirely different.

The delayed discharge issue tends to focus on old people who are admitted to hospital, sometimes in an emergency as unplanned

admissions, and then who cannot be discharged because social care packages are not available for them. There are a number of ways to tackle that, but that is not really the main area of activity for our membership.

The Convener: On A and E, we have a final question from Gillian Mackay.

Gillian Mackay: I am particularly concerned about regional variations in waiting times between health boards. For example, in NHS Forth Valley, which is in my region, for the week ending 24 October, only 51.8 per cent of people attending A and E were seen within four hours. That was a considerable improvement from the figure of 41 per cent for the week ending 10 October, but it was still considerably lower than the national average. NHS Forth Valley will be subject to the same acute pressures that exist elsewhere. I wonder whether Dr Thomson has an insight into why particular health boards seem to be struggling with that more than others are.

Dr Thomson: You raise a very valid point. The demands on emergency departments are unrelenting, and the performance on the four-hour standard for the month ending September was the lowest since records began. We have more patients waiting for more than eight hours and more patients waiting for more than 12 hours than we have ever had before, and that results in crowded and unsafe emergency departments.

For the week ending 31 October, there was no major emergency department in Scotland that did not have patients waiting beyond eight hours, and all bar one had a number of patients waiting for more than 12 hours. Indeed, in some departments, some patients are waiting for many days for a bed. That simply reflects inadequate capacity in the system for patients who need to be admitted to hospital. On average, emergency departments admit about 30 per cent of the patients who attend—the vast majority are seen and discharged—but that 30 per cent are waiting far longer for beds, and we know that patients who wait for that length of time come to harm.

Gillian Mackay: Do we have a sense of why certain health boards are struggling with the issue more than others are? Is it because of the number of consultants in particular health boards or is it, say, an issue of geography? NHS Forth Valley, which I have used as an example, is a relatively urban health board and its A and E numbers are worse than those of NHS Lanarkshire next door, which is on a higher crisis footing. Do you have any particular insights into why some health boards are struggling more than others are?

Dr Thomson: You mentioned the variation across Scotland. Some emergency departments deal only with emergency department patients, while others are the conduit for all admissions to a hospital. In some hospitals, patients who are referred from primary care will go directly to a ward, while patients in hospitals in other board areas will wait for a bed in the emergency department.

There is significant variation across the country, but the main issue that is causing the very poor performance, which equates to very poor patient experience with regard to the length of time that patients are waiting in emergency departments, is the lack of bed capacity in the system. We estimate that, nationally, we are short of approximately 1,000 acute beds, and unfortunately the expectation as we head into winter is that patients will have to spend longer and longer in emergency departments and will therefore come to more harm.

Gillian Mackay: Thank you for that useful insight.

The Convener: We need to zero in on some specific areas, so I ask colleagues to direct their questions to particular witnesses. First, Evelyn Tweed has some follow-up questions on social care.

Evelyn Tweed: My questions, which are for Annie Gunner Logan, are about capacity in the social care sector. I know that there is an acute shortage in my Stirling constituency, but can you give us a flavour of the general picture across Scotland? How can we help with the issues that are being experienced in remote areas?

Annie Gunner Logan: Capacity is a big issue. As I think I mentioned earlier, we surveyed providers on their recruitment issues, and some of the findings related to capacity. The providers were all pretty large organisations that operate in multiple local authority areas, and of the 30 that responded, 63 per cent—or just shy of two thirds—said that they had already had to reduce capacity for service delivery as a result of recruitment shortages. I have to say that we were surprised that the figure was as high as that.

Also, 53 per cent of those providers—more than half—said that they had refused or would have to refuse any new care packages even if commissioners came to them and asked them to take them on. Those are pretty significant numbers. We have not seen anything like that before the current period, when we are 18 months into a pandemic and approaching the winter.

The situation is serious. What we can do about it very much hinges on how we get more people into the workforce. The social care workforce is very different from the NHS workforce. Typically, the NHS model is that people train, qualify and then start work. In social care, people start work and then they train and qualify. We do it the other

way round, and a lot of recruitment is more values based. It asks what kind of person someone is and whether they are the right person to do this kind of work. If they are, we get them in and then we start to train them and get them qualified.

The kinds of issues that colleagues talked about in discussing how long it might take for nursing and medical staff to come through the system do not really apply in social care. If social care was an attractive enough option for people, they could start tomorrow. We need to make it more attractive for people to start tomorrow. In remote and rural areas, that means social care being able to compete purely on pay with retail and hospitality. Overall, it goes back to fair work, making social care something that people want to do and making sure that people understand what it is.

At the beginning of this evidence session, I talked about the value that is placed on social care and what people think it is. It is not just a pressure belt for the NHS and it is not just about "time and task" personal care. It is actually about standing alongside people and supporting them to live their best lives. That is what social care is about, but we do not hear a lot about that. We also do not hear social care mentioned in the list of public services that people like to speak about when they are on platforms. Doctors, nurses, teachers and so on are mentioned, but social care is nowhere. A whole lot of awareness raising needs to be done there.

In the immediate term, we could get people through the door tomorrow if it was attractive enough, particularly in pay terms. It is really as simple as that.

Evelyn Tweed: Thanks, Annie. That is really helpful.

Paul O'Kane: My question is also for Annie Gunner Logan. I have heard a lot about unpaid carers being in crisis because they feel that they cannot access the packages that they need or because they have been told by their local authority that their package will have to be scaled or cut back. In relation to care at home, that is the case not only for older people, but particularly for people who have learning disabilities. From the work that you do with providers and your survey work, do you have the sense that there is something of a crisis for unpaid carers, too?

Annie Gunner Logan: Yes, I think so. Some of that is also a hangover from the pandemic. I said that our sector does not need remobilising because we have been here all the time, but there are exceptions to that in congregate care settings. We know about care homes, but there has been very little focus on buildings-based daytime opportunities, and especially on short breaks for carers—what we used to call respite.

A lot of those settings had to close at the beginning of the pandemic simply because of the restrictions on the numbers of people who were allowed to meet indoors and social distancing. Those buildings-based congregate settings could not admit people any more. That has meant that a lot of family carers have not had a break at all for 18 months—they have had no support whatsoever.

That relates to something that I was going to ask the committee to consider. You have a lot of providers on your panel this morning—including me, as that is who I am speaking on behalf of—but there are also a number of user-led organisations that have a lot of information on the issue. Inclusion Scotland is one of them, and there is the Glasgow Disability Alliance and the Coalition of Carers in Scotland. They have been tracking what has been happening to people's support, and it is not a particularly happy picture.

It is not for me to tell the committee what its business should be, obviously, but I thoroughly recommend that, at some point, you have a session with those organisations, because you would get some rich information that would come from the people who have lost out on receiving social care. I can talk about the staff, the providers, the impact on the sector and all the rest of it, but the really important thing is what is happening to people who rely on social care. The capacity issues that we have in the sector have had quite an impact on them, for sure.

12:00

The Convener: I would like to move on to questions about improving outcomes. That has been alluded to in everything that we have talked about so far. How we improve health outcomes for people over the winter is really the crux of the matter, and witnesses have pointed to quite a few of those areas. Emma Harper has some specific questions on that.

Emma Harper: This evidence session is looking at planning for winter and how we can improve outcomes. I am the co-convener of a few cross-party groups on healthcare, including the one on health inequalities, and we know that we need to improve the outcomes for many people. Earlier, we heard from the minister, Maree Todd, about the women's health plan. Do any of you have specific proposals for improving outcomes, not just for the winter but in the future?

The Convener: Would you like to direct that question to anyone in particular?

Emma Harper: Let us go first to Annie Gunner Logan.

Annie Gunner Logan: That question goes to the heart of what we are all here for, does it not? Our recipe, if you like, for improving outcomes was contained in our submission to Derek Feeley's review of social care. There are a whole range of approaches to improving outcomes. For us, fundamentally, it means that we drop the whole idea of competitive tendering for social care. That takes us nowhere in relation to improving outcomes. It is about having a skilled workforce, which is discouraged by competitive tendering and the current commissioning arrangements.

It is also about standing alongside people and letting them make their own decisions. Interestingly, for us, the national care service consultation did not have quite enough to say about that, or about the importance of self-directed support. In social care, that has been legislated for for eight years now. The whole point of self-directed support is that people identify their own outcomes and then the role of social care is to support them to achieve those. That, for me, is the absolutely essential part of all of this. We need to be really serious about self-directed support. We need to implement it properly, put more resources behind it and get it moving.

That is certainly what Derek Feeley said in his report, so at the moment there is a little bit of a mismatch between what he said and the proposals for the national care service, as they stand. I think that the job that we all have to do over the next few months is to make sure that they realign. The best people to tell you what outcomes they want to achieve are the people whom we support.

John Mooney: Unison's long-time stance is straightforward: having a highly trained and valued workforce is the best thing that we can do to improve standards in social care. We have been pushing for that throughout the Feeley review and the national care service review. That work has got to be centred on the fair work principles, and that is certainly the direction in which we should be going. We talk about an overnight fix for the staff shortage issues. Lots of the fair work principles are not going to deliver overnight success, but in the medium to long term, that is the route that we should be going down.

I will probably not surprise you when I say that the conflict between private profit and care that provides a top-notch service is clear for Unison to see. I am disappointed that private profit appears to be accepted in the national care service proposals. Lots of members who responded to our survey said that, even though they are struggling to provide the services that they currently provide, there are still organisations out there tendering for new services. In essence, members are saying that, if they had the level of training that they need, things would be a lot better for service users on the ground.

Sharon Wiener-Ogilvie: We need to shift some of the resources to prevention and early intervention or think more about how we can develop resources for that. Prior to the pandemic, we had begun to see that shift, but the needs of the population have changed because of the pandemic, and there is a requirement for more therapeutic intervention and longer rehabilitation. A lot of the allied professions workforce has therefore been diverted to address those acute issues rather than focusing on prevention and early intervention. For example, it could be about supporting people with low-level or medium-level frailty in the community so that they do not access A and E or acute services. We need to shift resources to that preventative agenda.

Emma Harper: My next question is about avoiding harm. The submission from the Royal College of Emergency Medicine states:

> "The data show that for every 67 patients waiting 8-12 hours, one of them ... will come to avoidable harm."

Obviously, we need to think about how that can be avoided. Data on each harm that occurs is required to be entered into a system so that it can be tracked. I think that it is the Datix system, which I know because I am a former nurse who used to enter adverse events into that system. How do we ensure that our GPs and our doctors have a wider ability to utilise the system to learn so that harm can be avoided in the future?

Dr Thomson: There is clear evidence that, adjusting for all other confounding factors such as age and deprivation, a wait in an emergency department of eight to 12 hours increases mortality for that admission. As you said, for every 67 patients who wait for between eight and 12 hours for admission to hospital, there will be one avoidable death that is related purely to that excess wait in an emergency department. That is absolutely unconscionable and it is completely avoidable with the correct capacity in the system. We do not know what harm that does not result in death is happening to those patients who are waiting for a significant time.

Emergency department staff are not trained to look after patients for many hours after their initial assessment and immediate management. Therefore, those patients, despite the best efforts of all our staff, are receiving poorer quality care than they would receive if they were in the correct bed under the correct in-patient specialty. There is no doubt that, as we head into winter, if we see a continuation in the long waits for beds in emergency departments, that issue will continue. These are not patients waiting to be seen; they are being seen within an appropriate timescale and

are then waiting many hours to move to an appropriate in-patient bed.

The Convener: We have a couple more questions to ask you all before we finish. Staff welfare has been mentioned many times. A number of colleagues wanted to ask specific questions about that. I ask them to make their questions direct and quick.

Sue Webber: Okay—I will try. I had a long question, but I will make this as succinct as possible. Given the challenges and restrictions, how feasible is it to provide nurses who work in the acute sector with the opportunity for flexible working, with a view to improving their wellbeing and retaining those members of staff?

The Convener: I guess that we will go to the RCN for that.

Colin Poolman: That is absolutely possible, and there should be no restrictions. We should look at all flexible working options for any individual who wants them. If that will retain someone in the service and help them to maintain their health and wellbeing, that is what we should do.

I do not think that there are any barriers to looking at flexible working in the acute sector or across the whole health and social care sector. We need to work much more with our workforce on what suits people's work-life balance, and that means looking at flexibility of opportunity and employment. I would far rather have individuals who can work some of the time and even extend their careers than—I will use this word—flog people until they feel that they have to leave. There are no barriers; it is about making choices available.

Sue Webber: Thank you. That is great to hear.

The Convener: The Government is looking to attract people who retired early to come back. Would the flexible approach that Colin Poolman talked about help to attract such people back?

Colin Poolman: That is a huge point, convener. There are people who have left whom we want to attract back. There were some pension implications in that regard, but there was a change as part of the pandemic emergency measures. Moreover, we have an ageing workforce and, given changes to pension provisions, we know that a lot of people are considering retiring now. We need to ensure that we keep that expertise in the workforce, to provide mentoring and support as well as patient care. Both things are important.

When we have got it right, we have seen a number of people come back during the pandemic—although not as many as we would have wanted or hoped to see. We must ask those individuals, "What did we do that made this work for you?" Then, we can improve the offer as well as retain individuals in the workforce. Individuals who choose to retire take so much experience with them, and we need them to support our newly qualified nurses and help them to develop into the best practitioners that they can be.

We absolutely need to look at the issue. We have been talking about it for years, as many members know, but we have not yet got it right.

John Mooney: I support that. In social care—I know from colleagues in the NHS that this applies there, too—staff are looking for a degree of flexibility in their work. Many people are considering moving on to the bank or have already done so, and the only reason for doing that is to gain more control over their shifts and how they work. We need a more modern approach that meets people halfway, so that we maintain service provision while giving people the work-life balance that they want. We really need to go down that route in the future.

Annie Gunner Logan: The general question was about staff wellbeing and welfare. As I have said before, fair work is absolutely top of the list, and access to wellbeing resources is important, too.

In our sector, it would also help enormously with morale if staff in commissioned services were not treated as second-class citizens, compared with people in the rest of the system. I said in our written submission that the uplift of the minimum wage for care workers to £10.02 is brilliant—it was a fantastic announcement—but the policy is now entangled in a load of implementation problems, which we think will make things worse rather than better for some organisations, simply because we are not viewed as an equal part of the system, compared with public sector employees. That is hugely demoralising for staff in our sector.

The same goes for organisations. In our submission, we talked briefly about some of the financial support that has been made available to the sector. That support is hugely important and we are very grateful for it, but the way in which it is being administered is an absolute catastrophe.

As third sector organisations, we all feel that we are slightly outside the loop. Parity of esteem would help tremendously with staff wellbeing, and for all of us working in the third sector. We are trusted enough to provide very intensive personal support to hundreds of thousands of people, but we are not quite trusted enough to deal with the money and the support in the same way that other organisations are. That really needs to stop now.

12:15

The Convener: We are coming to the end of our session, but Paul O'Kane has questions about lessons learned from dealing with Covid last year.

Paul O'Kane: Thank you very much, convener. I appreciate that we are tight for time.

We are still living through the pandemic, and last winter was unprecedented. I am keen to understand how you feel about the lessons learned from last winter. Has the Government learned what worked and what did not work so well, and have those lessons been factored into the winter preparedness plan?

Dr Thomson: The winter demands that we see year on year are entirely predictable. In my experience, we put in place short-term mitigation measures over that period, and we do not put in longer-term solutions that allow us to deal with fluctuation in demand. For example, over this period, it is entirely normal to reduce the amount of elective surgery to accommodate the increased bed space that is required for unscheduled care admissions. We do that every winter and, as the numbers of admissions decrease, we revert back to normal.

I think that it will be the same again this winter. Short-term mitigation will be required, and I do not see anything having changed that makes things any different for this coming winter compared with any previous winter. There is very much an element of cross our fingers and hope that we cope.

Paul O'Kane: We see those pressures every winter, and I take your point about elective surgeries. However, do you feel that the unusual circumstances of the pandemic and the cancellation of more and more elective surgery will create a problem for us at the other end of winter?

Dr Thomson: Yes. I think that any remobilisation plan that has been discussed or published in regard to Covid recovery, particularly in relation to waiting lists in surgery, has not taken into consideration unscheduled care. Without doing so, it is likely to fail.

There needs to be a single overview of the capacity that is required for unscheduled care. Although it is unscheduled, it is relatively predictable. We know at which points in the year we are particularly busy and at which points we are not. The concern this year is that, during autumn, which is normally relatively a quieter time, we are at our worst-ever performance. It is far worse than that in any previous winter, and we are not yet in winter.

What will happen again is that medical patients will be admitted to surgery beds, because that is where the capacity is in hospitals.

The Convener: Annie Gunner Logan wants to come in. We will then have to wind things up.

Annie Gunner Logan: On the question about what we have learned and not learned from last year, I have long come to terms with the reality that, on behalf of our sector, I tend to say the same things that I said the previous year and the year before that. That is also true this year.

Staying positive, the Feeley recommendations and the national care service proposals would go a long way towards supporting social care in the way in which it needs to be supported in the winter or at any other time. However, that is a very long way off.

On the Scottish Government learning lessons, I think that there is a broad understanding of what needs to be done, but we are not doing that yet. I go back to what I said about the long-term prospects being quite positive but some very rapid action on some of the issues being needed in the short term. Unfortunately, a lot of that action will require money.

Quite a lot of money has already been allocated. The £10.02 per hour pay is brilliant, and we are all very pleased about it, but I am not sure whether it will do the job this winter. Some of the implementation methodology around it and some of the other financial support that we have are just not doing it. We need an injection of urgency and speed into some of the solutions that we already know will work.

The Convener: Thank you. Unfortunately, we have gone over our time. I thank everyone who has given evidence this morning. If there is anything that you want to follow up on, the committee is always here to receive emails and letters about specific issues on which you feel that you did not get time to express a view. Everything that the witnesses have said this morning is extremely helpful to us.

At our next meeting, on 16 November, the committee will take evidence from the Minister for Mental Wellbeing and Social Care on session 6 priorities.

12:20

Meeting continued in private until 12:38.

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