OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 29 March 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

13th Meeting 2022, 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:

Humza Yousaf (Cabinet Secretary for Health and Social Care)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 29 March 2022

[The Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Convener (Gillian Martin): Good morning and welcome to the 13th meeting in 2022 of the Health, Social Care and Sport Committee. I have received apologies from David Torrance.

Agenda item 1 is a decision on whether to take item 5 in private. Do members agree to take that item in private?

Members *indicated agreement.*

Alternative Pathways to Primary Care

The Convener: Our second item is a further evidence session as part of our inquiry into alternative pathways to primary care.

I welcome to the committee Humza Yousaf, the Cabinet Secretary for Health and Social Care, and his officials, who are participating online: Naureen Ahmad, the head of general practice policy division; Tom Ferris, the chief dental officer; Alison Strath, the chief pharmaceutical officer; and Michelle Watts, the senior medical adviser, all from the Scottish Government. Good morning to you all.

I invite the cabinet secretary to make a brief opening statement.

The Cabinet Secretary for Health and Social Care (Humza Yousaf): Good morning to you, convener, and to the committee members. I hope that you are all keeping safe and well.

I am pleased that, as one of your first inquiries, you have chosen an area often referred to as the bedrock of our health and social care services, which is, for most people, the front door to accessing the health service.

I am impressed that the committee has gathered quite a diverse range of views from both primary care providers and, importantly, the wider public who use those services. It has been extremely interesting to read the feedback and the comments of contributors to the evidence sessions over the past months.

As in most areas of health and social care, we have engaged in significant redesign of primary care both before and during the pandemic. It goes without saying that the contribution that primary care services make each day to the health and wellbeing of Scotland through continuity of care and meaningful relationships with patients is foundational to our public services. I thank every single member of the primary care family for their incredible efforts during the pandemic.

Prior to the pandemic, we were already engaged in significant reform of pathways through the 2018 general practitioner contract. That has been a real step change in primary care pathways in the community, with people able to access a wider range of healthcare professionals through their practice while freeing up GP time to focus on more complex care.

By March 2021, 2,463 staff had been recruited to the multidisciplinary teams—over two and a half whole-time equivalent staff per practice—and that number will have risen significantly over this year. For our part, we have allocated every penny of the

£360 million investment committed to recruit those teams over four years, and we are delivering a further £170 million investment as part of the 2022-23 budget to continue the expansion of those important MDTs.

Injecting that additional capacity into practices has been a real boon in allowing our wider primary care system to respond flexibly to the pandemic, staffing Covid hubs and assessment centres and supporting the Covid vaccination roll-out while keeping core GP services going to address the wide array of patient issues.

On those core services, it is worth pointing out that, even before the pandemic, video and telephone consultations were part of how care was delivered in general practice. Over time, as restrictions ease, the balance will shift towards more face-to-face appointments—as it should—but a mixture of appointment types will remain a core part of general practice, as we know that it suits many patients to have consultations with their GP over the telephone or over video.

It is not just general practice that has made significant adaptations throughout the pandemic and changed to meet the needs of its patients while keeping them safe. For example, we launched NHS Pharmacy First Scotland in the summer of 2020, which has increased the range of common clinical conditions that the community pharmacist can treat.

NHS 24 has also seen a significant increase in demand over the past year as a consequence of Covid, the expansion of mental health hubs, and access through 111 to the national redesign of urgent care, all delivered 24/7, where previously NHS 24 operated largely out of hours.

As we look to the horizon and to recovering from the worst of the pandemic, it is important that we continue to shape our pathways to address the demand that has arisen, and that we learn from the experience of the pandemic.

As I said, GPs are usually the first port of call for people who are seeking professional help for mental health issues, and the vast majority of mental health consultations occur in primary care, covering a diverse range of needs. That is why, by the end of this session of Parliament, we will have invested in 1,000 additional mental health workers in primary care.

Primary care services often deal with far more than clinical issues. That is why we are investing in providing non-clinical and social support and advice, including support for individuals who are experiencing social and financial disadvantage and exclusion. Staff such as community link workers, welfare advisers and mental health workers can help with those concerns.

We are committed to a range of recommendations on tackling inequalities, following the publication of an expert group report last month. I see the focus on mental health and health inequalities as complementing and further developing the primary care reforms that we have already instigated.

We will continue to commit our efforts towards having more multidisciplinary and multi-agency working, and to shifting our focus to the community to ensure that we get the right care to people at the right time.

I am of course happy to take questions from the committee.

The Convener: Thank you, cabinet secretary.

As you mentioned, it has been a number of years since 2018, when the Scottish Government started the reforms relating to pathways and multidisciplinary teams. Previously, there was a traditional model in which the GP was the first, and often the only, port of call for people to access healthcare. Obviously, the plan is to widen that out.

One reason why we decided to do our inquiry was that, from speaking to stakeholders, we got a sense that public awareness of the issue is not quite where it could be. Certainly, we had a lot of responses to that effect in our survey of patients across Scotland and in discussions with patient groups. The model that the Government wants to promote is not quite landing in every area of Scotland. What are your thoughts on how the Government can take forward the approach and create a culture change? How can you give assurance to patients that an alternative pathway is not a wrong pathway, that they do not have to see their GP for everything, and that in fact it might be better to access an alternative pathway?

Humza Yousaf: That is a fair comment, and that message came out loud and clear from the various evidence sessions that the committee held. I have a couple of points to make on it. First, I hope that for the vast majority of people who have accessed and had treatment from the various members of a multidisciplinary team at a GP practice—whether that is the physiotherapist, the advanced nurse practitioner or the pharmacist—the service that they received will have been expert and extraordinarily helpful. I have no doubt that, as more and more people get access to such individuals, they will absolutely understand the value of the multidisciplinary team model.

Secondly, the issue of communications has been raised with me by not just patient groups but clinical representative organisations such as the British Medical Association and the Royal College of General Practitioners, the latter of which I met

just a couple of weeks ago. There are a couple of things that we can do on that. First, the work that we are doing with the Health and Social Care Alliance Scotland is really important, and it will be well known to you, convener, and to other committee members. We recently commissioned the alliance to conduct a qualitative survey of patients' experience of accessing general practice, which forms part of a wider 10-year monitoring and evaluation strategy for primary care.

The pandemic has been challenging for us. One thing that we can all recognise is that so much of our marketing and communication has gone into how to behave during Covid: the latest Covid regulations and rules, rules around testing and self-isolation and so on. As we recover, there will still be Covid communication—we are running a Covid sense marketing campaign at the moment—but I hope that we can begin to rebalance some of that communication to the public. That is about the redesign of the urgent care programme and the message that, even if you are not seeing your GP, it might be better for you to see another member of the team at the GP practice within the community.

As part of that, at the end of last year, we delivered a leaflet to every single household with an accompanying letter from the chief medical officer and the national clinical director. That well-produced leaflet showed the various pathways for someone to access treatment and what services people could expect from GPs and the other pathways, including pharmacy first and NHS 24.

I take the point and do not disagree that there will be something of a cultural shift. We are very focused on that.

The Convener: The pharmacy first and minor ailments services have been more successful than other routes. Are there any specific areas where a little more work needs to be done to give patients confidence? In particular, I am thinking about those patients who say, "I need to see my GP", and feel that they are being fobbed off when another route is suggested to them. That is a key point in the cultural mindset.

Humza Yousaf: You are spot on, convener. That is why, this month, we have launched a specific campaign to support our receptionists. A couple of weeks ago I was at Taymount surgery, where I had a discussion with Dr David Shackles of the Royal College of General Practitioners. When you walk into the surgery, it is immediately obvious how busy the receptionists are.

Unfortunately, we have heard reports of receptionists facing abuse over the phone and sometimes in person. I am sure that everyone around this table will agree that that is completely unacceptable. It does not matter what pressure the individual is under or their need to see a GP or a member of a GP practice—aiming abuse at our receptionists or any health and social care staff member is unacceptable.

Clearly, there are people who feel that receptionists act almost like a kind of gatekeeper. That is why we launched a campaign this month to explain that when receptionists redirect patients it is being done because that is in the best interests of the person's clinical care. There may be others who can see the person and that will allow the GP, as an expert general medical practitioner, to focus on complex cases. I hope that will result in a better experience for the GP and, most importantly, a better experience for the people we are looking to serve.

The Convener: I have one final question before I bring in Carol Mochan. You mentioned a better experience for GPs. Given that GP workload is extremely pressurised, do you think that when the model starts to kick in and there is public acceptance of the fact that there are several different ways to access care, it might make GP practice more attractive to medical graduates because they will be dealing with acute cases, which will really put their training into action, as opposed to the nurse practitioner side of things?

Humza Yousaf: That is certainly part of the feedback that we get. The focus on being an expert medical generalist makes that option more attractive. Easing the workload burdens so that GPs can focus on more complex cases also helps. There are also other issues around retention. I am well aware that there is a practising GP on the committee and I would be very interested to hear his thoughts. The feedback that we get from GPs is that the contract and the work that we are doing around MDTs in particular—if we get it right and embed it—will make general practice a more attractive proposition. Having said that, last year's fill rate was about 98 per cent so we are doing well. However, retention is an important issue and this approach could be key to retention.

The Convener: Thank you. Carol Mochan has some questions now.

09:45

Carol Mochan (South Scotland) (Lab): I am really pleased that you have listened to the evidence, cabinet secretary. It is clear from the evidence that patients see GPs as the gold standard, so it is understandable that they sometimes find this alternative way of working quite difficult. It is our responsibility to try to support them to use these new routes in a way that makes them feel engaged and valued and that they are getting the best treatment.

It is clear from the evidence that the committee has taken—and I hear this in my constituency all the time as well—that patients feel a bit passed around; they feel that the systems are not working very well and that there is no clear leadership at the health board level on how those pathways work. We have also heard quite a number of times about people who have gone all the way round the system and back again. I would suggest that there is some urgency around sorting that out and that it probably requires some serious financial investment. Where are you with that in relation to your plans for the next few years?

Humza Yousaf: On the point about serious financial investment, our £360 million investment to deliver those multidisciplinary teams is a sign of the importance that we attach to this, so I hope that we would meet that ambition.

I also know—as do Carol Mochan and the rest of the committee members—that the past two years have been absolutely unbelievable in terms of the pressure that everybody across the national health service and social care has faced. If we did not have a pandemic, I do not doubt for a minute that we would be able to use more of our communications muscle and the weight of the Government to get some of those key messages out. All that being said, I take Carol Mochan's point that, during a pandemic, it is perhaps even more important to be doing that.

On people feeling that they are being passed around, that is something that I hear too and, again, it is a fair comment. From our perspective, that is why we have worked and are continuing to work on the digital health and care strategy. The strategy is available online and I am certain that members will have seen it—if you have not seen it, I recommend that you look at it. It lays the foundation for that cloud-based architecture where information can be shared a lot better than it currently is. We know that that area still needs significant improvement.

I think, though, that with the embedding of community link workers, for example, the sharing of information about a patient is better, so that people are not passed around as much, whether that relates to third sector support, primary care, or secondary care.

It is extremely important that the interface between primary and secondary care is working. Every time that I meet the BMA and RCGP, they stress to me the importance of that interface working, so that people are not passed between primary and secondary care—which, in fairness, is a bit of an artificial boundary that we have created as opposed to a boundary that means anything to patients, who just need to receive treatment or diagnosis or care for the condition that they have.

Carol Mochan: The key thing to remember is that patients are central to this, so their experiences are really important to move it forward. I urge the cabinet secretary to make sure that there is a serious commitment to alternative pathways, because we all believe that that will ensure good outcomes for patients.

The Convener: We move on to the workforce and capacity.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): Changing how the public access primary care is key to making this a reality: alternative pathways must deliver for patients. In evidence, we have heard about long waiting lists that can encourage patients to default to going to the GP. How will the Scottish Government improve staff capacity and reduce waiting times? Is there enough investment in recruiting staff to deliver the Scottish Government's vision?

Humza Yousaf: That is a really good and important question. There is no getting away from the fact that in the past two years there have been significant increases in backlogs.

As was stressed to me by a number of orthopaedic consultants whom I met recently, it is important to recognise that being on a waiting list is not benign, but comes with serious and significant impacts on the individual who is waiting. Those impacts can include deterioration in health and an increase in chronic pain. Patients who do not know how long they will have to wait for their procedure or operation often manage their situation by going to primary care or their GP practice. I entirely accept that there will undoubtedly continue to be a level of pressure on primary care as the backlog for treatment continues, so tackling the backlog will be key.

Of course, key to tackling the backlog is controlling transmission of Covid. Between the delta wave and the omicron wave—between last October and November—we had a bit of a breather; that, alone, allowed scheduled operations to increase by around 23 per cent within the space of a month. We know that the NHS has the ability to recover if we can somehow insulate it from the worst impacts of Covid-19.

Staffing is also key, but I will not rehearse in too much detail our good record in that respect. I am not saying that there are no vacancies—we know that there are—but the more than 28,000 additional whole-time equivalent posts that have gone into our NHS under this Government is an impressive record.

My third point is that the issue is why we are investing heavily in the multidisciplinary team model. For people who are waiting for an operation that has, unfortunately, had to be postponed due to the pandemic, visiting the

physiotherapist in their GP practice might have real importance and value and could, at the same time, free up GPs to be expert medical generalists and to deal with more complex cases. Stephanie Callaghan's point is well made and important, and highlights why the NHS's recovery is so vital.

Stephanie Callaghan: It is good to hear you mention multidisciplinary teams, and it is great that they are expanding to include physios, pharmacists, occupational therapists, mental health nurses, dentists, optometrists, psychiatrists and paramedics. The teams are getting bigger and bigger all the time; it is important that they do so.

However, concerns have been raised in previous evidence on workforce planning that we will end up just moving people around instead of creating the new capacity that we need. We have also heard about the importance of investing in and integrating workforce planning across primary care and other services. How will the Scottish Government create new capacity in implementing workforce planning in primary care and services across the board?

Humza Yousaf: You have again said little that I would disagree with. A concern that we have always had is that we must not, in creating multidisciplinary teams, merely take things away from other services in the community. That concern is particularly valid, given the pandemic's impact on the ability to attract staff from outwith Scotland to this specific programme. I should say that the same concerns surfaced in the early years of reform, but they have levelled off in recent years.

We are confident that there is genuine additional capacity in primary care to complement existing teams. In the recruitment of MDTs, we are seeing much greater emphasis on training and on "growing your own". A good example of that is pharmacotherapy. The plans for years 1 and 2 were very pharmacist-heavy, if I can put it that way, but recently the skills mix has been moving towards use of pharmacy technicians, with a projected 75 pharmacy technicians in post for every 100 pharmacists in 2023, compared with the current figure of 29 for every 1,000. Just for reference, I point out that training a pharmacy technician takes about two years, which is considerably less than it takes to train a pharmacist. It is important that we have that pipeline for the future to ensure that we do not end up cannibalising the existing workforce.

I am keen to attract much of the workforce from other parts of the United Kingdom and from the common travel area, as well as from overseas. We are putting a lot of emphasis on international recruitment. I was pleased to see some of our international nurse recruits in NHS Fife recently. That was in a hospital, on the acute side in secondary care, but there is also a role for them in primary care.

Stephanie Callaghan: I have a final question. It is nice and short, but I am not sure that the answer will be nice and short. What might the implications of the national care service be on capacity and workforce planning?

Humza Yousaf: I will try to be brief. That issue has definitely gathered a fair bit of attention. Again, it will not be a surprise to anybody—I will not be articulating a state secret—when I say that, in our conversations, the RCGPS and the BMA have voiced concerns about some of the consultation proposals to move GPs from their current employment model into being employed as part of the national care service. We are yet to come to a determination on that but, at this stage, I think that they make quite persuasive and strong arguments for retention of the current employment model.

However, let us see how we are truly integrating primary care as part of the national care service. We have to do that, because integration has to be key. I will be careful what I say, because we are still going through the consultation responses, but with regard to the reformed integration joint boards proposal, again, we hope that there will, from the inception and creation of the national care service, be real integration with, for example, health boards. That will be vital. We are considering the consultation responses.

I have to be careful, because we are hurtling into the pre-election period, but my desire is to pick up the conversations—in particular with the Convention of Scottish Local Authorities—in earnest after the elections. I want to do so very quickly; I hope that the legislation on the national care service will be introduced to Parliament before we go into the summer recess. I look forward to being able to articulate our vision for the national care service in that period.

Stephanie Callaghan: Thank you; that is very helpful.

The Convener: Sue Webber has questions on workforce and capacity.

Sue Webber (Lothian) (Con): Hello, cabinet secretary, and thank you for coming this morning.

As you know, recruitment and retention in general practice continues to be a critical issue as we recover from the pandemic, but even before Covid, the Audit Scotland reports were showing that the Scottish Government's plan to increase the GP workforce by 800 by 2027 is on course to be all but wiped out by the number of doctors who are expected to retire or change their working patterns. What needs to happen to improve retention among general practitioners?

Humza Yousaf: That is a great question. You are absolutely right that, although we can be ambitious on the recruitment side, if we do not retain those staff, the value of that recruitment is questionable.

I hear a number of things from our general practitioners and people who work as part of GP teams. It goes back to some of what the convener was saying. If we ensure that the burden of the workload is eased and spread out across multidisciplinary teams, that absolutely helps. Again, I do not think that it is giving away any secrets to say that, when I speak to GPs, they tell me that they are exhausted.

The second thing that we need to ensure is that we remove potential disincentives. For example, the BMA asked me to look at whether there is anything that we can do on pensions. I have written to the UK Government on that, but I am also looking to see what the Scottish Government might be able to do with regard to pension schemes. I have not come to a firm conclusion yet, but I am looking at the matter with an open mind.

We also need to continue to make progress with the current contract. I hope that the next phase of the contract will not only make becoming a GP an attractive proposition but will make staying in the profession attractive. There is a lot that we can do, which we are already working on, and there is more that we can do, which I am giving active consideration to. Sue Webber's point is absolutely right—we have to focus on retention as much as we do on recruitment.

10:00

Sue Webber: I have one more question. What assessment have you and your team made of provision of GP out-of-hours services during the pandemic?

Humza Yousaf: We keep that under regular review, as you would expect. It would be fair to say that there have been some challenges. There has been a focus on out-of-hours services in a number of health boards, with NHS Lanarkshire and NHS Forth Valley having been looked at most recently. We continue to keep the matter under review. There have been challenges throughout the pandemic and we are still in a very tricky position, but I hope that, as the pressure eases, we will be able to make out-of-hours options more attractive and sustainable.

We know that people need out-of-hours access. The demand on NHS 24 services, which has gone through the roof in recent months, is an example of that. We keep that under regular review, but I also recognise that there have been challenges.

The Convener: A number of colleagues want to ask about workforce issues.

Paul O'Kane (West Scotland) (Lab): My question follows on from some of those that have been asked already and is about the data that is available. Figures from Public Health Scotland show that the number of whole-time equivalent GPs has gone down: we are at the lowest level since 2013. Although the head count is going up, the whole-time equivalent number is a better yardstick in helping us to understand the picture of services across the country.

We have not had any figures on whole-time equivalent GPs since 2019. I do not know whether the cabinet secretary has any information about that; if so, the committee would be keen to see it and to know where we are with whole-time equivalent GPs. Can you commit to providing that information?

Humza Yousaf: Yes, I can, if that is not management information and it can be published. Even if it is management information, we will find a way of ensuring that it is quality assured and that we can publish it. I am happy to write to the convener, who will be able to pass on the information.

Paul O'Kane knows our commitment to increasing the head count. He is right to point out that difference. It is a significant target. I go back to the point that I made to Sue Webber and others: it is just one part of our strategy for ensuring that we have a sustainable GP service in primary care. Retention will be a key part of that.

Paul O'Kane: I thank the cabinet secretary for that commitment.

Emma Harper (South Scotland) (SNP): I am also thinking about recruitment of GPs. The Scottish graduate entry medicine programme is unique to Scotland and was created as a collaboration between the universities of St Andrews and Dundee to support training of GPs. I assume that that is going well. This might need a longer answer than we have time for today, but I would like a wee update on how ScotGEM is going.

Humza Yousaf: The programme is going well. For the sake of brevity, it would be better for me to write to the committee with more detail. We are continually looking at how we can expand the ScotGEM programme and increase its capacity because of the value that we have seen even in its early years. My written response to the convener will include a number of things that I want to come back to the committee about and I am happy to give you some more detailed data about how that programme is going. Whenever I have conversations with my primary care team about

GP services, ScotGEM is always seen as a critical component of that.

Emma Harper: The programme has a particular focus on rural general practice.

Humza Yousaf: Absolutely—that is the primary focus of that work. I do not need to explain to Emma Harper that there are real issues with how rurality affects GP recruitment and retention. ScotGEM is an absolutely vital part of tackling that. We are taking forward some work after the report by Professor Sir Lewis Ritchie. I spoke to him last week about that work, which will be vital for sustainability. It is absolutely key to the rural challenges that we continue to face in GP practice and in primary care more generally.

The Convener: Sandesh Gulhane is joining us online with a question about the workforce.

Sandesh Gulhane (Glasgow) (Con): My question goes back to one of the things that you said about pensions. In Wales, they have solved the issue of doctors paying to go to work through pensions by recycling of employers contributions. That allows the doctors who are in danger of paying to go to work to come out of the scheme. It is a fairly good solution, and it also brings in more tax because the money is taxed. My question is why we have not gone down that route more quickly, because it seems to be working in another devolved nation.

Humza Yousaf: Yes. As I understand the situation, it is also the position in England that NHS trusts can bring forward recycling employers contributions schemes. You are right to point out that that option exists in England and Wales, which is why I am actively considering it.

However, I also have to think carefully about the financial impact on the Scottish Government of that support for a group of clinicians who work incredibly hard but are, we would all accept, at the higher end of the pay scale. What about the people who are at the lower end of the pay scale? We need to remove disincentives, but we should also put money and resources towards the people at the lower end of the pay scale, which is the progressive thing to do.

I am certainly not ruling out introducing a REC scheme. In fact, far from ruling it out, I am doing the opposite and am actively considering it. I expect to be able to say something more on that in the coming months; it should not take longer than that. We are in the middle of discussions on pay for agenda-for-change staff and we are waiting for recommendations from the review body on doctors' and dentists' remuneration. We are at a really important juncture when it comes to discussions around pay and terms and conditions, but the REC scheme is being actively considered and discussions on the scheme and its effects are on-going with the Welsh and UK Governments.

The Convener: Evelyn Tweed has some in-depth questions on signposting. She joins us online.

Evelyn Tweed (Stirling) (SNP): Good morning, cabinet secretary. You mentioned the key role of receptionists, including in primary care reforms, and said that receptionists are often seen as a barrier rather than a facilitator. How we can improve interactions between patients and receptionists? You also made a point about raising the profile of receptionists.

Humza Yousaf: I refer to my earlier comments. First, we abhor any abuse of any staff. It is unacceptable. Also, we know that receptionists are a vital component of the GP and primary care team, so any abuse that they suffer is unacceptable. We have heard evidence of such abuse from a number of sources, which is why the big messaging campaign in primary care at the moment is focusing on the role of receptionists.

We launched our receptionist awareness-raising campaign across Scotland on 3 March. It is aimed at the general public and raises awareness of the important role that receptionists play. If anybody here has not seen the advert, I commend it to you. We are happy to send a link to the video in our letter to the convener. It is an excellent advert that shows the various pathways that are available, and shows that receptionists are trying their best to be helpful.

Receptionists are not trying to be blockers or gatekeepers, or to be difficult. They are caring for the person on the other end of the telephone line while they are under significant pressure themselves and saying, "Actually, we think that the best route for you is X, Y or Z." Messaging is definitely part of it. My appeal to people is to understand that, although I know how difficult it can be—it is frustrating, too, I imagine—the demand on services means that patients cannot get consultations straight away, so it can feel as though they are being fobbed off, but that is not what GPs or receptionists are doing.

We had, some years ago, a short-life working group that focused on the role of receptionists, which we will restart; it will meet in April for the first time since the pandemic. The group is chaired by Fiona Duff, who is senior adviser to the primary care directorate, and it will focus on development and the future needs of GP practice managers and admin staff. We can pick up the matter in that working group and look at the future role of receptionists.

Evelyn Tweed: How do we ensure that, while we are promoting alternative pathways to primary care, patients can consistently access the most

appropriate care for their needs? What safeguards will be in place?

Humza Yousaf: For me, this is about ensuring that we invest in multidisciplinary teams. I have every trust that the clinical advice that a person will receive will mean that they get the best care possible. For example, someone might be signposted towards physio, but the physio might be so interconnected with the rest of the multidisciplinary team that they could say, for example, that the best thing for that patient would be to see the pharmacist, because their mixture of medicines might be having a side effect that was causing their issue. The patient would then be passed on to the pharmacist who might be able to provide a different medicine or a combination of different medicines that will help with the patient's pain.

We have to trust in that clinical judgment—I certainly do. In those few instances where things go wrong, which we must acknowledge can happen, there are avenues for pursuing complaints, but I would hope that in the vast majority of cases, because clinicians are working as part of a multidisciplinary and multi-agency approach, people will get the right care in the right place at the right time.

The Convener: Sue Webber has a supplementary question.

Sue Webber: I want to follow up Evelyn Tweed's point about the role of the receptionist. Some of the papers talk about gatekeepers, but they are also called signposts or gateways. I realise that that is all about positive versus negative language, but the point is that the people accessing these MDTs still have to contact a particular individual, and that is often still the bottleneck that causes the frustration. How might we overcome that?

Humza Yousaf: That is a really good question. There are a few things that we can do, but I will try to keep my answer brief.

For a start, we are investing in telephony systems. In fact, we have provided health boards with around £2 million for that. We might cover this a bit more later on, but digital access to health services is also hugely important, which is why, as part of a digital healthcare strategy, we talk about the digital front door. In future, there could be less reliance on having to rush to phone at eight in the morning, for example, and having to hit the redial button 16 times to either get or not get an appointment. That is frustrating for everybody: it is frustrating for the receptionists, who I expect are feeling quite anxious at 7:59 am, and I suspect that it is pretty frustrating for the individuals at the other end. Digital will have a real role to play in that.

Paul O'Kane: Receptionists are not the only staff in GP practices. We have heard about signposting and gatekeeping and all sorts of things, and we had some good evidence from Dr Graeme Marshall, who talked about reception teams training with clinical staff and the more administrative staff. Do you see any opportunity to standardise some of that training?

Because of the nature of GP practices, this would be hard, but perhaps we could look at the pay and conditions of those on the more administrative side and how we might enhance their roles. After all, we know that they are doing more than just answering the phone and talking to patients.

Humza Yousaf: I agree with all those points, and that is why the discussions that are being had with the BMA and the Royal College of GPs are really collaborative. Given the independent contractor model that we have, it is important that we keep close to our GP colleagues in relation to the terms and conditions that Paul O'Kane has rightly referenced. I go back to my answer about the short-life working group, which is meeting again next month and is looking at the very issues that Paul O'Kane has highlighted around administration, development and training. Those are very key points.

The difficulty lies with standardising things across the country. That has its benefits, for sure, but it also has its disadvantages with regard to flexibility for more rural and remote areas. That said, I do not disagree with Paul O'Kane's substantive points.

10:15

The Convener: I call Sue Webber, who has questions on social prescribing.

Sue Webber: Cabinet secretary, one third of the respondents to the committee's public survey said that their experience of social prescribing was either bad or very bad, with some saying that they would be insulted to be directed to those services. A common theme among respondents was that they could have found the same or better information elsewhere. You get a bit of a sense of frustration in those responses. What needs to happen to ensure that these pathways are perceived as—and, indeed, are—more valuable and credible to the public?

Humza Yousaf: Again, that is a really good question. You said that a third of respondents gave that response. I will need to look at the survey, but I hope that that means that the majority of people, then, found social prescribing quite helpful as a pathway. However, that third is still significant. It is not an insignificant number of people.

A few things need to be done. First of all, we need to be able to extol collectively the virtues of social prescribing. I am a real believer in the ability of social prescribing to have a positive impact on people, because I have seen it at first and second hand. I have seen it in my own personal experience, and I have seen it as a constituency MSP. I have a fantastic community link worker in Pollok, and she has just taken over from an equally fantastic community link worker at the health centre in Pollok. I am, in some sense, an evangelist for social prescribing.

Social messaging, too, is absolutely needed and is key to this. Given what you have said, perhaps the Government needs to think about how we can articulate the virtues of social prescribing. It is not just about signposting people to X, Y or Z service in their local community; it is about the relationship that a link worker builds up with an individual and their being able to say, "This is how I think this or that service could support you", and taking that journey with them. I think that that is key.

It is fair to say that there is an issue with consistency across the country, and we have commissioned Voluntary Health Scotland to develop a national network of community link workers where they can share best practice and act as peer-to-peer supporters for each other. The question, though, is: how will they share that knowledge across the country? Voluntary Health Scotland is undertaking a review of the support and training needs of link workers, and it will build on those findings, too.

There is a lot to do in this space, but I hope that, for most people who experience an interaction with a community link worker, the experience is a very positive one.

Sue Webber: You say that you hope that people are having a good experience, cabinet secretary, but I note that in its response to our consultation Healthcare Improvement Scotland suggested that an increase in social prescribing was dependent on continuous monitoring. Are you aware of the monitoring that is being undertaken? If so, how extensive is it?

Humza Yousaf: Again, I am probably prejudging the findings of the review that will come through, but we tend to leave how local community link workers work and interact with the third sector and community groups to the link workers themselves and their expertise, as well as to the general practice that they work in and the other members of the multidisciplinary team whom they work with. There is not some kind of standardised, one-size-fits-all top-down approach where we say, "Here's what we think you should do, and here's how we think you should do it." We have to have that local flexibility, because what works for the community link worker in my constituency in Pollok is not necessarily going to work for a community link worker in Peebles, Perthshire or somewhere else beginning with P that is not Pollok. Retaining that local flexibility is clearly important.

What we are hearing back—and I think that this is central to your question—is that people want to know how we are monitoring the impact of link workers. I would say that we probably have a bit of work to do at a national level on monitoring that impact in greater detail.

The Convener: Gillian Mackay, too, has some questions on social prescribing.

Gillian Mackay (Central Scotland) (Green): Good morning, cabinet secretary. Witnesses have told the committee that a culture change is needed with regard to social prescribing, because many patients are still not comfortable with the idea. Some organisations heard that people felt short-changed when they were redirected to links practitioners rather than a GP, and GPs also made the point that time constraints limited their ability to explain social prescribing to patients. What action is being taken at the national level to facilitate that sort of thing and to promote and explain social prescribing and its benefits to the public?

Humza Yousaf: I will try not to repeat what I have already said in too much detail. We have done the marketing and communications around social prescribing, but we might want to up the ante on that, particularly given the effects that the pandemic has had on people's mental health. Social prescribing can play a real role in helping people overcome some of those mental health challenges, so we need to re-energise some of the national communication on it.

I hope that, as the expansion of the MDTs eases the workload pressures on GPs, they will have the time to explain to individuals that social prescribing is not about being fobbed off or passed on but that there is real value in what a community links worker can do. It is really valuable to have them embedded as part of the team. We have work to do on that, but it is the right way to go. Indeed, that is why we have committed to having 1,000 mental health workers in GP practices in the future. There is real value in those individuals connecting with services in the community.

There is more to do on that, and perhaps we need to think a little bit more about the national messaging with regard to the value of social prescribing.

Emma Harper: I am interested in social prescribing, too. The question is how we signpost folk to some of the services that exist. In this inquiry, we have focused on helping people signpost patients to additional third sector services using a local information service for Scotland—ALISS—which is the Government-funded local

information system. At our previous meeting, we also heard about the resource that the Edinburgh Voluntary Organisations Council provides and the DG locator service in Dumfries and Galloway.

I am interested in hearing how we can enhance and give better support to ALISS and in considering how we direct people to mental health services. We have seen the benefits of men's sheds, walking football, walking groups and other social groups that the third sector can help to direct people to. How do we support ALISS in signposting people?

Humza Yousaf: You make a good point about ALISS. I did not get to see the evidence sessions, but I read the evidence that you took, and what came across clearly is that although ALISS had the potential to be a really important tool, it was not being updated enough and its functionality could be better. That feedback from the committee's evidence sessions has been really helpful to us in that respect.

ALISS is a great resource. It includes more than 5,500 services that are available from more than 800 organisations, so it has a significant amount of detail, and it was searched more than 26,000 times in the three months from October to December last year. However, we recognise that some work needs to be done on what is an important tool. Indeed, some of that work is being done at the moment. Work to enhance the performance and accessibility of ALISS is being undertaken by the alliance, and we hope that that will be finished this summer.

Emma Harper: That is good to hear.

I was also thinking about how we direct people. For instance, we have had some feedback that people go and see their GP and expect to be given tablets for their type 2 diabetes, for instance, when maybe a social prescribing programme could help reverse that condition. We saw that in the television programme "Fixing Dad", in which Geoff Whitington, who weighed 20 stones, managed with support from his family to lose a lot of weight. What else can we do to show people that alternative pathways are adjuncts and are not necessarily class B rather than class A things? We have seen, especially during the Covid pandemic, how important it is to support people's mental health by, say, getting them outside and walking.

Humza Yousaf: I do not think that there is any magic wand or magic bullet, but communication is certainly part of the approach. The more we can give people access to social prescribing, the more they will see its value as individuals, and they will then—I hope—let other people know about the benefits by word of mouth. Clearly, we will do what we can. In a previous answer, I said that there might be a role for more national messaging, and we could perhaps link with the third sector on some of that. However, when people hear stories about those who have experienced these benefits, such as the one that Emma Harper articulately put across, that sort of thing speaks volumes compared with what a Government marketing campaign can do, although maybe there is something that can be done on case examples. Those stories and personal experiences are hugely important.

I have mentioned our expansion of mental health workers, which absolutely could include community link workers, but could go even broader than that. As more and more of those individuals get embedded in GP practices, more and more people will have access to them, will—I hope—benefit from them and will speak to others about the positive impact on their lives.

Emma Harper: Thank you.

The Convener: We will move on to talk about digital health and care, with questions led by Paul O'Kane.

Paul O'Kane: We have heard evidence from patient groups, particularly the Riverside patient participation group, which I think is from Musselburgh, about digital exclusion and health needs. Those two things coincide. We understand that approximately 10 per cent of the population do not have access to new technology or the skills that are required to use it, and that those people are the most likely to have the greatest health needs—there is a clear correlation. I am keen to get a sense from the cabinet secretary of how those patients' routes into primary care can be protected and enhanced, given the challenges.

Humza Yousaf: We are conscious and aware of that issue. If you have not read the report that was published by the short-life working group on primary care and health inequalities, I would definitely recommend it to you. You may well have done so already, but if you have not—I know how busy we all are—it is certainly worth taking a bit of time to go through it. The points on digital exclusion are well made by the likes of Dr Carey Lunan, who was involved in the working group and is part of the deep-end project, of which I know members are aware. That project involves 100 GP practices in the most deprived areas, and those who are involved in it often talk to us about digital exclusion.

I have a couple of points on that. One is that, with anything that we do in the digital space, we have to ensure not just that we are aware of and acknowledge digital exclusion, but that there is an alternative pathway for people who just do not have access digitally. No matter how hard we try, there will be some people who do not feel comfortable or are not able to use digital routes,

so we have to ensure that alternative pathways are available for them.

10:30

The other thing that we should do—and we are doing this—is focus on digital inclusion. As you would imagine, I work closely with colleagues across Government on that agenda, which is important to all cabinet secretaries and ministers. The connecting Scotland programme aims to support an additional 300,000 households to get online. We need to connect as much of Scotland as possible, but we must also accept that alternative, non-digital pathways will be important for some people, and that is part of our thinking.

Paul O'Kane: We have also had discussions—I have been slightly banging on about this—about the need to provide digital spaces in locations in our communities. An obvious example that comes to mind is libraries. I have spoken before about how we can use libraries—and improve and protect their services—so that people can access digital services where they need to. That does not necessarily have to be in the main, public part of the library; there are definitely spaces elsewhere where people can be supported to do that in communities.

In a lot of communities, particularly in rural locations, the GP surgery is one of the few amenities, so it becomes the hub and focus. A challenge or a barrier can be that people might not want to go online alone at home. How do we ensure that an increasing number of facilities are available to people in community settings where they can access information and advice, or indeed get a consultation, online?

Humza Yousaf: Again, you have said nothing that I disagree with. Investing in our public services locally is so important. The member referenced libraries. A library in my constituency has not only a public space, but a quieter space where people can go online should they need to look at something that is particularly sensitive, subject to all the appropriate checks and safety measures that we would expect.

The member makes a good point in relation to exploring whether we can do more in GP practices and health centres. It would probably be easier to do that in larger health centres. We would need to consider how to do it in smaller locations where space is already at a premium. I will take that point away.

Sue Webber: We spoke earlier about some of the changes to services, including to the telephony system for GPs. The adoption of digital health and care information has accelerated through the pandemic, but has the quality and quantity of resources kept up with demand? Are the relevant websites easy to navigate, including for those who have only a limited digital understanding?

I am trying to figure out whether we are keeping up with the technological development that is needed. I am thinking back to an article that was in *The Scotsman* the other week about an app on which people can access test results, make appointments and so on. That is not available to us in Scotland, but NHS England has such an app available now. I wonder why there is not a bit more cross-border sharing of that technological development.

Humza Yousaf: I will say a couple of things on that front. During the pandemic, there has been an explosion of interest in digital health and the accessing of health information digitally—out of necessity, no doubt. NHS Inform is a good example of a service that has been well used throughout the pandemic. I can perhaps share in my written response to the convener some of the data on how well NHS Inform has been used. That is also true for other digital platforms, with Near Me being the obvious example—its use has exploded.

Sue Webber's point about a digital app is really important. One of the SNP's manifesto commitments is to develop an NHS app, which will be a digital front door. We are working on that. Where it is sensible to have that discussion with other parts of the UK, we are doing—and will do—that. There is no point in reinventing the wheel if something already works particularly well. I know that you are not suggesting this, but we might not just be able to pluck an app from one part of the UK and transplant it here.

We have a really good relationship with the other health secretaries and ministers throughout the UK, so we can share that information and knowledge, and I would be keen to do that. There is a lot of progress to be made in that area. We are very focused on a potential digital front door app that can do a host of things from picking appointments to receiving results.

Sue Webber: In previous evidence sessions, some of the Government officials who work with the digital platform stated that there is a disconnect between Scotland and other parts of the UK on the level of investment in people who develop such technology. Do you have plans to upscale that and have more people working behind the scenes to develop the digital platform?

Humza Yousaf: In short, yes. The digital team hears from me regularly that more investment and resources will come their way. I am committed to that, because the current digital team needs to be beefed up. They are a great team—they do a heck of a lot and, blooming heck, they have worked really hard throughout the pandemic. There is

value in not just upskilling but increasing the numbers in that team.

As I said to our health board chief executives and chairs yesterday, when we talk about infrastructure, we put a lot of focus on bricks and mortar. That is understandable because it is important to build health centres, hospitals and community services, but I think that we should put equal focus on investing in digital infrastructure. In the discussion yesterday, there was lots of broad agreement on that.

The short answer to your question is yes. The digital team in the Government will be appropriately resourced, and that resource will undoubtedly have to increase to meet our ambitions.

The Convener: I was going to ask you about Near Me, which you mentioned. One of the few positive things that has come out of the pandemic is the face-to-face or videoconferencing aspect of healthcare. For some people, that has been really helpful, and they might want to opt to use it in the future. The word "opt" is important here. Will there be an assessment of the lessons on digital healthcare that have come out of the pandemic, and the things that we may want to keep and invest further in?

Humza Yousaf: I entirely agree with your articulation of that. Telephone consultations, video consultations and face-to-face consultations are all parts of the hybrid model. Even given the current pressures, there are people who should be seen face to face, and if that is not happening, I am not happy about it. In the future, however, as we look towards that hybrid model, continuing with video or telephone consultations will be the preferred option for many people.

That is the preferred option for me. I have used it during the pandemic. Trying to show the doctor the back of my knee, where I have some eczema, was not necessarily the most comfortable experience, but we got there, and it worked well. That was in the morning, and the ointment that I needed was at the pharmacy down the road by the afternoon. It saved me from having to take time out of quite important meetings to travel to my GP, sit in the waiting room and get assessed. For me, it worked perfectly. For many people who have work pressures, family pressures and so on, it will be far more convenient to be seen by video or have a telephone consultation.

I make the point, which in some respects goes back to Paul O'Kane's point about digital inclusion and exclusion, that we have to be really careful that people who are digitally excluded are digitally included as much as possible. However, I accept that that will not be the case for everybody, and alternative pathways have to be available. Nobody is talking about removing the need for face-to-face appointments. No GP that I have met has ever suggested that, and we want to work collaboratively with GPs on the matter.

It is probably worth stating that it has been quite upsetting to see, in some of the public discourse in the press and involving politicians, finger pointing and, almost, blame being directed towards some elements of primary care, including GPs. That undervalues the really important contribution that GPs and the entire GP staff have made. I am really thankful for their efforts.

I also understand the frustration of people who try desperately to get an appointment but are unable to get one. That is the challenge that the pandemic has caused. However, I have no doubt that, as we ease our way out of the pandemic, or into a more endemic phase, access to primary care will improve.

Emma Harper: I mentioned rural areas earlier, and we are talking about digital inclusion and exclusion. We have found that people in rural areas have used digital access to have telephone or video calls for mental health consultations. Will we continue to measure that to see how digital access benefits people, with those in rural areas being able to see somebody? People should still be able to see someone face to face, because that might be the best way forward for some people, but it could be quite positive for people in our rural areas if they could continue to use NHS Near Me, for example.

Humza Yousaf: Absolutely. There is little for me to add, because Emma Harper has articulated the matter well. There is a continued role for the hybrid model, but it might be particularly important in rural areas and for island communities. That goes back to my earlier point about the need to ensure—as the Government is doing—that there is good digital coverage across the entire country. We know that that is particularly important in remote, rural and island communities. Our investment in that respect speaks for itself. I have little to add, other than to agree with Emma Harper's assessment.

The Convener: We will move on to talk about the single electronic patient record, which came up frequently in our other evidence sessions.

Stephanie Callaghan: A couple of weeks ago, we heard strong evidence about the importance of the single electronic patient record and the need for easy, seamless and secure access to shared health and care records at the point of care. We were told that the single electronic patient record will improve continuity of care and ease frustration for patients and workers. Last week, we heard evidence from digital professionals, and good progress seems to have been made on a central

cloud-based platform that will allow different systems to talk to one another. There was also mention of pilots in the data strategy engagement programme.

Can you provide a bit more information on the positive progress that we have made towards creating a national digital platform? Will you commit to keeping the committee updated on that work?

Humza Yousaf: Again, I can be relatively brief. All the points that you have made are priorities for us. There is recognition that the sharing of information and data is crucial to ensure that people are not passed from pillar to post, which relates to Sue Webber's earlier point.

I have just double-checked the details, and the digital health strategy is clear about how important cloud-based architecture could be. Again, I commend the strategy to anybody who has not seen it. Details of the national digital platform are on page 18.

We do not necessarily need a single product, which could take a lot of time and considerable investment. It is the integrated approach to cloud-based digital components and capabilities that will play an important and significant role in the data sharing that Stephanie Callaghan talked about.

Investment has been made, and it has to continue to be made, because the issue is not without financial implications. Some of the work is already under way, but it is incumbent on me, in my role, and the Government to accelerate that work, given the challenges that the pandemic has created and will, I am afraid, continue to create for our health service for many years to come.

Stephanie Callaghan: I know that a few of my colleagues have questions, so I will leave it there.

The Convener: Sandesh Gulhane, who joins us online, has a question on data.

10:45

Sandesh Gulhane: Cabinet secretary, as you have just said, data is vital. However, as a GP, I cannot see what my psychiatric colleagues have written, and when I was doing my psychiatric block, I could not see what the child and adolescent mental health services doctors had written, even though I was covering for CAMHS overnight. We have patients who have to tell their story and repeat it. There are occasions on which, although we have the key information summary service, the out-of-hours provider is unable to see what I have written, and vice versa.

All in all, the sharing of information in a patient's journey is not currently adequate, which is a real safety concern. What can we do quickly to try to solve that? Secondly, when there is data sharing, what are the data protection implications that arise?

Humza Yousaf: Those are both good questions. I defer to Dr Gulhane's expertise in that regard. He speaks from professional experience, and he has articulated well some of the safety concerns, as he rightly put it, around the sharing of data.

We often talk about data as though there is not a person behind it, but there very much is, and there may be potential implications for that individual. Again, I commend to Dr Gulhane our work in the digital health and care strategy, which outlines clearly what our actions are and how we are undertaking them. They are being undertaken at pace, as the national digital platform work is very much under way. It is under new leadership within NHS National Education for Scotland, and we are investing in it.

It would be wrong for me to say that that will be done overnight or in a matter of weeks. Some complex digital IT solutions will have to be found as the work develops. Nonetheless, going back to the point that I made to Sue Webber, I note that that is why the Government investment in that team is so important.

On the second part of the question, Dr Gulhane makes an important point. We are all aware of the importance of ensuring that we safeguard that very sensitive health information, which can relate as much to people's mental health as to their physical health. Our digital strategy states clearly that one of the key pillars is about ensuring that information governance is "at the heart of" that work. That includes the need to ensure that the right and appropriate assessments—I am talking about data protection impact assessments and equality impact assessments—are carried out.

The confidentiality of patient medical records is at the heart of the strategy, and the need to ensure that we live up to our responsibilities in sharing such data is at the core of everything that we do. As I said, it is a key component of the national digital health and care strategy.

The Convener: We move on to the theme of inequalities, which has, as we expected, come up throughout this session and in all the previous sessions in this inquiry. Questions will be led by Gillian Mackay.

Gillian Mackay: In a previous meeting, I asked witnesses about the inverse care law and how, as the system becomes more complicated to navigate, with people being expected to self-refer to different services, we mitigate the risk that those with lower levels of health literacy might become less likely to engage with health services.

Witnesses highlighted that "targeted communication" is vital, in addition to

"detailed analysis of the data that is being collected on ... who is accessing different services directly instead of through GP referrals".—[*Official Report, Health, Social Care and Sport Committee,* 8 March 2022; c 25.]

What action is the Scottish Government taking on that, and what plans are there to collect and analyse that data?

Humza Yousaf: That is another really good question. I commend the short-life working group's published recommendations to you, if you have not already seen them. The key issue is data, and although our data collection is relatively good, when it comes to inequalities it could be far better.

Another key issue is the development of services through co-production with the people who are most affected by the changes. The work that we are doing with patient groups, particularly in areas of deprivation, where inequality is greater, demonstrates the need to develop services with those individuals.

We now have a development group, which will take forward a number of the working group's recommendations. I have instructed that team to ensure that we co-produce work with people who experience inequalities at the sharp end.

That is not to place an additional burden on such individuals, who have enough to deal with in their daily lives, as we all do. However, qualitative data in that regard is important. We have robust quantitative data, but the qualitative piece can add significant value.

Gillian Mackay: We know that, in urban areas, there are sometimes barriers to people attending different sites for appointments and so on. Could geographical variations in the provision of alternative pathways exacerbate inequalities, particularly for people in rural areas, where the distance between appointments might be significant?

Humza Yousaf: I hope that I can reassure you as much as possible that we are very much aware of that point. We hope to mitigate some of those challenges, in everything that we do. Part of the conversation that we are having will be about whether we need to look at transport solutions, for example.

The question that Emma Harper asked a moment ago is pertinent. Can something be done to ensure that, instead of people in some parts of Scotland having to travel 50, 60 or 70-plus miles to a service, they can access services remotely, through digital means, in a way that is not currently available?

For people who end up having to travel, whether they are in an urban or a remote and rural landscape, it is important that we put solutions in place at inception, as opposed to designing a service and then thinking, "Goodness, there are challenges here that we will have to try to fix." The issue is a fundamental part of our thinking about services as we move forward.

Gillian Mackay: Thank you.

Carol Mochan: I want to take this opportunity to raise what is an extremely important issue as we change pathways. Screening definitely needs looked at, because the significant difference in uptake, particularly among women and girls in deprived areas, can lead to very different outcomes. Cabinet secretary, are you prioritising screening? Are you ensuring that opportunities are taken up in deprived groups, particularly as pathways change?

This is an important question. As it makes changes, particularly to primary care, does the Scottish Government ensure that all its policies and practices are health inequality proofed?

Humza Yousaf: The agenda is important to all of us, and I recognise that you have raised it regularly in this committee and in the chamber.

We recognise the importance of screening, which has the ability to save lives, across a variety of cancers. I recognise your point: we know that there are disparities in screening uptake between people in the least deprived areas and people in the most deprived areas, which is why there is a lot of focus on how we increase uptake.

I discussed that very issue recently with officials who are involved in the national screening programme. We talked about, for example, how we use mobile screening units. From memory, I think that we have more than 20 mobile screening units—and I should say that I am referring here to breast cancer. How do we use those mobile units to get into areas of higher deprivation? That illustrates some of the work that is being undertaken as we speak.

Going back to a point that Gillian Mackay made in her first question, how do we get more targeted communications to individuals in the areas of highest deprivation?

The third point that we are thinking about is how we ensure that there are appropriate voices from those communities where uptake is lower—among ethnic minority communities, for example. I know that you have asked about that. There are often intersectionalities with deprivation. In certain screening programmes, the uptake for ethnic minority women is lower than for their white Scottish counterparts. How do we use voices from minority communities—as opposed to a middle-aged white male doctor, for example, who of course has great clinical expertise but might not

be as impactful as a female doctor from an Asian background, for instance—in speaking about the importance of going to screening appointments? There is a lot of effort and work going into that, as we recognise the disparities that exist.

Carol Mochan: Do you have a plan within your department for equality proofing policies?

Humza Yousaf: Yes. We have well-established plans, as you know, with an equality impact assessment, and we would test any policy of significance within that assessment. To give you some level of assurance when it comes to our health policies and the initiatives that we pursue, I can say that, in the 10-odd months I have been Cabinet Secretary for Health and Social Care, I have not had a discussion about the initiatives that we are pursuing that has not included some sort of discussion about inequality at the root of it.

The figures are stark, and they speak for themselves. Therefore, a concerted effort in all areas of health policy, not just screening, absolutely must be focused on driving down those inequalities. I can reference the work that the excellent primary care health inequalities working group has done, which we just published earlier this month.

Sue Webber: We know that screening saves lives and that early detection saves lives. A lady who is over 70 has contacted me, and she is desperate to get a breast screening. Due to some medication that she is on, there is a significant increase in the risk of her getting breast cancer, yet she has been denied that. What can we do? She should be able to access treatment and screening equally with anyone else, specifically given the risk factor that has clearly been identified. How can we help this lady in particular?

Humza Yousaf: I thank Sue Webber for what is a really important question. I hope that she will take my answer in the spirit in which it is intended. I hope that, fundamentally, she will choose to believe that the decision that we have taken about self-referral for those who are 71-plus has not been taken lightly. It was a really difficult decision to take.

Just a couple of weeks ago, I spoke to those who are leading our screening programme—the breast-screening programme in particular—about this very issue. In the fundamental decision that we have to arrive at, we need to consider that, for the women at the highest risk, those in the 50-to-70 age bracket, the period when they are waiting between screens is currently too long. There is no doubt that the pandemic has had an impact—I am thinking about the difficult decision at the beginning of the pandemic to pause those screening programmes and then restart them in the summer of 2020.

The gap between screening programmes is, I think, around 39 months—forgive me if that is incorrect; I will correct that when writing to the convener. If we were to introduce the self-referral route at the moment for those who are aged 71-plus, the estimate is that that would add a further four months to the gap between screening cycles. The question, which I have asked officials to explore with pace, is whether the benefit of the over-70 referral route outweighs the additional few months that might be added on to the gap between screening cycles, which we must accept will happen if we take that decision.

11:00

That work is under way, because I am very aware that the self-referral route is open to older women in other parts of the UK. There is a difference between the UK nations in that regard, but the matter is being explored and I hope to have an update in the relatively near future. I am not a clinician, and I need a clinical view on whether, if we were to increase the gap in screening, that would have a significant impact or whether any impact would be outweighed by the benefit.

Sue Webber: I understand what you are saying.

The Convener: Sandesh Gulhane would like to ask a final question.

Sandesh Gulhane: We have touched on the issue of inequality being not just about wealth, with rurality causing an inherent inequality. It is clear that staffing issues are not evenly distributed around the country. Earlier, you extolled link workers and spoke about how good they are. I love my link worker and think that they are brilliant. However, link workers are not available to people in areas such as Forth valley or Aberdeenshire. At the heart of ensuring that we have equality, we must ensure that the staff who are available in Glasgow or Edinburgh are available throughout the country.

Therefore, how will you ensure that areas that are hard to recruit to and which do not have staff will get the staff, and that that process will be rolled out in a manner that means that such an approach will be at the heart of recruitment strategies?

Humza Yousaf: That is a really important question. First and foremost, where we can incentivise recruitment and retention in rural areas, we will certainly do that. Emma Harper spoke about the ScotGEM programme, which is an excellent example of that. There are also golden hellos, bursaries and the rediscover the joy programme. There are a number of programmes that I could point to in which the focus is on rural recruitment and retention.

Our ambition is to have 1,000 community link workers and mental health workers recruited by 2026, so that they are available in every GP practice in the country. I assure Sandesh Gulhane that that element of rural provision and island provision is central to our thoughts in that respect.

Sandesh Gulhane: Incentives such as golden hellos are important in encouraging people to go to such areas, but we have heard that there are significant differences in the pay of our colleagues, depending on where they work. We were told in evidence that sometimes such workers are band 3 and sometimes they are band 4, which makes a huge difference to the amount that they make.

There is no point in incentivising someone to take a job in a particular area if they will make significantly less money, so should we standardise the level that our allied health professionals start on and then add on incentives to get people into those rural areas that are harder to recruit to?

Humza Yousaf: I can absolutely see the argument that is being made; Sandesh Gulhane articulates it well. The difficulty here is not the mechanism because, ultimately, it is possible to do that if there is a desire to do it.

However, when we talk about the 1,000 additional mental health workers, they could include various different workers. A GP practice might not need an additional community link worker; they might prefer to have somebody who has specific mental health expertise. We must be cognisant of the fact that there are workers with different specialities in different practices.

The second thing is that, if we impose a national structure, will that remove the flexibility that is required in various localities, including in our island and rural communities? Is that a trade-off worth making? The answer to that might well be yes, and we are exploring that in committing to an additional 1,000 mental health workers. We just have to be careful that we do not remove local flexibility entirely. However, I take Dr Gulhane's point and I assure him that it is all part of the thinking and development of the additional 1,000 mental health workers that we are committed to.

Emma Harper: I have a quick supplementary question. I understand that community link workers will be required to carry out different duties, depending on where they are working in a local authority or health board area. According to a freedom of information request that has been published on the Government's website, there were 218 link workers in post at the end of March 2021.

I know that there has been a pandemic for two years, and that is why some of the data might not be as up to date as we would like, but there is a projected total of 323 link workers by March 2022. I am interested to hear the cabinet secretary's thoughts on that. I reinforce the point that link workers might be doing different things across different health boards, and we should support the health boards to know their own area and to support their GP practices, whether they be rural or urban.

Humza Yousaf: There is little for me to add to that, other than to say that that is part of the reason why we have left it as broad as saying that we are committed to an additional 1,000 mental health workers. For some areas, a community link worker with all their different specialties might be important, but it might be more important for a GP practice to have a specialist in a particular area of mental health such as, for example, young people's mental health. We want to allow local areas to have that flexibility. It is also why the relationship with the integration authority at the local level is really important, as is the relationship with the third sector.

There is little more for me to say other than that I agree with Emma Harper's assessment of retaining that local flexibility. As I have said previously, that is the tension that we sometimes have to work through, because there are challenges around standardisation and good arguments are made for why it is necessary, but it could have a diminishing effect on local flexibility. That important discussion is under way and we need to continue with it.

The Convener: Cabinet secretary, thank you for all your answers this morning, and I also thank your officials.

We will take a 10-minute break before going on to our next item.

11:07

Meeting suspended.

11:20

On resuming—

Subordinate Legislation

Prohibition of Smoking Outside Hospital Buildings (Scotland) Regulations 2022 [Draft]

The Convener: Agenda item 3 is consideration of an affirmative instrument. We will take evidence from the Cabinet Secretary for Health and Social Care, Humza Yousaf, and Scottish Government officials Claire McGill, solicitor, and Jules Goodlet-Rowley, head of the healthy living unit, who are joining us online. Once all the committee's questions have been answered, we will have a formal debate on the motion.

I believe that you have an opening statement, cabinet secretary.

Humza Yousaf: Thank you very much, convener, and thank you for letting me stay on to talk about these important regulations, at the heart of which lies the proposal to set up no-smoking perimeters around NHS hospital buildings.

As we will all agree, hospitals should be places of health promotion, where healthy ways of living are demonstrated, and environments in which people are protected from harm and are supported in making positive lifestyle choices. Unfortunately, though, it has become commonplace to see patients, visitors and, at times, staff standing and smoking close to hospital buildings and their entrances, despite an existing voluntary ban on smoking on hospital grounds. Those entering and leaving buildings, some of whom are vulnerable and very unwell, might have to walk through smoke, and there is no means of reproaching those who ignore the request not to smoke.

Our current tobacco action plan, "Raising Scotland's Tobacco-free Generation", confirmed our intention to progress the work that is needed to introduce a mandatory ban on smoking near hospital buildings. The regulations support the existing voluntary ban by introducing fixed penalties and fines for those who smoke near hospital buildings or who allow others to smoke there. By effectively extending the successful 2005 ban on smoking in enclosed public spaces to areas outside buildings, they reduce the risk of exposure to second-hand smoke near entrances and windows and prevent smoke from drifting into hospital buildings, ultimately protecting those, particularly the vulnerable, who use hospitals. Because smoke from a single cigarette can be detected from at least 9m away, and because weather conditions and wind speed can cause further drift, we propose a perimeter of 15m, focusing on the high-traffic areas where people leave and enter buildings.

Just like the indoor smoking ban, the regulations are primarily about behaviour change. They denormalise the act of smoking by making it socially unacceptable to smoke near hospital buildings, and they reinforce the NHS as an exemplar of health promotion. Smoking can be a hard habit to break, and people are advised to seek support in doing so. Anyone smoking within the perimeter could receive a fixed penalty of £50, and any individuals who are taken to court could be liable to a fine not exceeding £1,000. Those who manage and have control of the no-smoking area are responsible for ensuring compliance, and should they knowingly permit someone to smoke there, they could be fined up to £2,500.

We will ask health boards and those who manage and have control of the area to work with local authorities on enforcement initiatives and arrangements to ensure compliance. The Scottish Government will provide all signage for hospitals, prepare information and ensure that everyone is aware of the change before it is introduced.

Every year, tobacco use is associated with more than 100,000 smoking-attributable admissions and, unfortunately, 9,332 deaths—in other words, one fifth of all deaths. It contributes significantly to Scotland's unfair and unjust health inequalities as both a cause and an effect.

Smoking rates have reduced from 31 per cent of the adult population in 1999 to 17 per cent in 2019, but we still have some way to go if we are to meet our ambition of 5 per cent or less by 2034. When asked, 66 per cent of smokers say that they want to quit, and I also note that a clear majority—over 70 per cent—of respondents to the 2019 consultation on the regulations support the proposals and see the benefits of removing tobacco smoke from NHS properties. It is now time to make that a reality.

I am happy to take the committee's questions.

The Convener: Thanks very much, cabinet secretary. A couple of members want to ask questions.

Paul O'Kane: Thank you for the statement, cabinet secretary. As you outlined, the legislation attracts a degree of support. My question relates to the responsibility for enforcement. The big challenge with many such interventions is that if they are not enforced, people will often become frustrated. I note from the meeting papers that the duty to enforce will fall on local authorities and their environmental health officers. What does that mean in terms of financial implications for local authorities? I refer to my entry in the register of members' interests as an out-going local authority councillor.

We know that, throughout the pandemic, there was extra pressure on environmental health teams due to enforcement of coronavirus regulations, and we know that that came with a cost. I notice from the paragraph in the report on financial effects that there will not be additional funding, because it is expected that additional costs will be covered from existing budgets. However, I am sure that the cabinet secretary will agree that local councils are stretched, and that there are huge challenges with the finance that is available. What scope is there to review the workload as the legislation is implemented and to consider what extra resources might be required?

Humza Yousaf: That is a good point, and I will say two things. Although there is a potential fixed penalty if someone does not comply, we hope that the introduction of the regulations, if they are passed, will enact behavioural change. I think that the vast majority of people will behave responsibly and make sure that they are outwith the perimeter if they want to smoke.

The second point is important—I agree with Paul O'Kane that we will keep the issue under review. In the local government settlement, there is baseline funding of £2.8 million for Scotland's local authorities to support measures that relate to tobacco control. There is baseline money there, so we do not think that there is a need for additional funding—certainly that need has not been articulated to me by COSLA. However, I will commit to keeping that under review, as Paul O'Kane has requested.

Sandesh Gulhane: Cabinet secretary, behavioural change is very important—of course it is—but I will give you two examples of the issue here. When I was at Yorkhill children's hospital, people were smoking by a big sign with a picture of a sick child on it that said, "Please don't smoke here—it drifts up to my window".

Forth Valley royal hospital has done more than I have seen other hospitals do. When I was there, it had big signs everywhere, and there was cross-hatching on the floor that said, "Do not smoke here". The hospital employed somebody who went round telling people not to smoke there. He tried to take details and issue fines, which was the right thing for him to do. He is a lovely guy, but people just abused and ignored him, as they ignore the other measures. If someone is standing in front of a picture of a sick kid and smoking, it will be really difficult to effect behavioural change.

Initially, like the indoor smoking ban, the measure needs to be policed, and it needs to be policed with teeth. I am picking up that point from Paul O'Kane as well. We need to police that really well, particularly at the start, in order to kick-start behavioural change. Will you look at that again to see what we can do to really clamp down in those initial phases?

Humza Yousaf: The point is well made. If the regulations are passed by the committee and Parliament, we will ensure that there is good education and public knowledge about them before they come into force in September. There would be time for us to ramp up the communications around them, which it is really important for us to do.

I take Sandesh Gulhane's point that people might not be paying attention to the voluntary ban that is in place. If someone is smoking, even if there are pictures of sick children on signs that say not to smoke, because the smoke potentially drifts up to their room, that is where the enforcement element could be quite crucial. If you end up paying that fixed penalty of £50, it is a really expensive fag to smoke. When the regulations first come into force, some health boards, in conjunction with local authorities, might choose to ensure that they are clamping down on those who are ignoring them.

11:30

I would expect there to be a sensible approach to enforcement, as there has been throughout the pandemic. Enforcement of the ban would not be heavy-handed to begin with but, if people ignore it and continue to ignore it, that option of a fixed penalty exists. Across the country, we may well see some people being hit in their pockets and realising that this is something that has to be done—it is not voluntary. I hope that the vast majority of individuals who smoke will understand the change in the regulations through our communications and will comply.

Emma Harper: I am interested in how the regulations will be communicated to the local authorities and health boards. As a nurse, I know about the exacerbations of chronic obstructive pulmonary disease that lead to hospital admissions. A respiratory care action plan is now being developed and will then be delivered. Tomorrow, I am heading to Belfast to talk at a Border and Regions Airways Training Hub—BREATH—project event, which is about COPD causes, prevention and treatment. It is welcome that we have these regulations. How will they be communicated to our local authorities and health boards?

Humza Yousaf: We will provide signage and we will work on providing information on the ban. Enforcement information will be available to patients in different languages as well, which is quite important, although the "No smoking" symbol is internationally recognised and that is why it is used. That being said, the information on the ban

is really important, so we will work closely with health boards on that.

If the regulations are passed—and I have every confidence that they will be—the period between now and the regulations coming into force will be really important for us. We will make sure that the information about the ban is communicated well, that there is a lot of attention on the ban's coming into force, and that the consequences of ignoring it are in place. That is all being discussed with local partners in advance of the regulations being passed.

Gillian Mackay: Do you see any difficulty around enforcement if a 15m no-smoking zone encompasses areas that are not part of hospital grounds, such as public footpaths?

Humza Yousaf: Potentially, people might think that they are far enough away. That is why the signage will be really important, to continue to reinforce the message that people are still within the no-smoking perimeter.

My hope is that, for the vast majority of people, that walk of 15m away is enough for them not to light up and have a cigarette. However, some people will still wish to smoke. That is why we need a period of time to remove smoking shelters, for example, from within that 15m boundary and make sure that they are outwith that boundary.

If there are areas for smoking outwith the perimeter, I hope that people will be cognisant of footpaths and other areas that people walk in, because if you are not a smoker, having to walk past a crowded smoking shelter and catching that second-hand smoke is an unpleasant experience. We know the dangers of second-hand smoke, which have been well articulated by a number of studies and third sector organisations—in particular, there is the good work that the Roy Castle Lung Cancer Foundation does in that regard.

Paul O'Kane: To follow on from that point, I understand that the regulations cover hospitals, particularly—

Humza Yousaf: Yes.

Paul O'Kane: Does the cabinet secretary feel that there is scope to extend that? We now have a number of new-build health and social care centres—very often in our town centres—that are well used, have treatment rooms and all the rest of it, so is there a sense that we should be looking to extend that ban across the estate more widely?

Humza Yousaf: The short answer to that is yes. We already have the voluntary ban in place for NHS hospitals—I should point out that it is NHS hospitals that we are talking about here—and it is perhaps easier to turn that voluntary ban into something statutory.

The problem is probably more acute in our hospital sites, given their size and scale. It is maybe less pronounced in a GP surgery, for example. I am not saying that it is impossible, but you are less likely to come across somebody smoking at the entrance of your GP surgery than at a hospital site.

I am definitely open minded about that suggestion, but I hope that members understand the logic behind progressing with this step first.

The Convener: As there are no more questions from colleagues, we will move on to agenda item 4, which is the formal debate on the made affirmative instrument on which we have just taken evidence.

I remind the committee that, during the formal debate, members should not put questions to the cabinet secretary and officials may not speak. I invite the cabinet secretary to move motion S6M-03434 and to speak to the motion, if he wants to do so.

Humza Yousaf: I have no remarks to make.

Motion moved,

That the Health, Social Care and Sport Committee recommends that the Prohibition of Smoking Outside Hospital Buildings (Scotland) Regulations 2022 be approved.—[*Humza Yousaf*]

Motion agreed to.

The Convener: That concludes consideration of the instrument. I thank the cabinet secretary and his officials for attending today's meeting. At our next meeting, on 19 April, the committee will take evidence from the Auditor General for Scotland on Audit Scotland's "NHS in Scotland 2021" report.

That concludes the public part of our meeting today. Thank you all.

11:36

Meeting continued in private until 11:58.

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