OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 28 November 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

© Parliamentary copyright. Scottish Parliamentary Corporate Body

Information on the Scottish Parliament's copyright policy can be found on the website - www.parliament.scot or by contacting Public Information on 0131 348 5000

Tuesday 28 November 2023

CONTENTS

Col.

DECISION ON TAKING BUSINESS IN PRIVATE ... 1
HEALTHCARE IN REMOTE AND RURAL AREAS ... 2
SUBORDINATE LEGISLATION ... 29
Food (Scotland) Act 2015 (Compliance Notices) Amendment Regulations 2023 (SSI 2023/161) ... 29
Feed Additives (Authorisations) (Scotland) Regulations 2023 [Draft] ... 29

HEALTH, SOCIAL CARE AND SPORT COMMITTEE
36th Meeting 2023, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Ross Greer (West Scotland) (Green) (Committee Substitute)
Dr Rebecah MacGilleEathain (University of the Highlands and Islands)
Dr Stephen Makin (NHS Highland)
Professor Annetta Smith (University of the Highlands and Islands)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 28 November 2023

[The Convener opened the meeting at 09:15]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning and welcome to the 36th meeting in 2023 of the Health, Social Care and Sport Committee. I have received apologies from Tess White.

The first item on our agenda is to decide whether to take items 4, 5 and 6 in private. Are members agreed?

Members *indicated agreement.*

The Convener: Thank you.

Healthcare in Remote and Rural Areas

09:16

The Convener: The second item on our agenda is a second oral evidence session as part of the committee's inquiry into healthcare in remote and rural areas. Today, we will hear from academics with expertise in rural health and wellbeing, nursing, geriatric care, delivery of rural healthcare and wider issues in remote and rural healthcare.

I welcome to the meeting Dr Stephen Makin, who is a senior clinical lecturer at the University of Aberdeen and honorary consultant geriatrician at NHS Highland; Dr Rebecah MacGilleEathain, who is a research fellow in the division of rural health and wellbeing at the University of the Highlands and Islands; and Professor Annetta Smith, who is a professor emerita at the University of the Highlands and Islands.

We will move straight to questions and to Carol Mochan.

Carol Mochan (South Scotland) (Lab): Good morning, panel. It is great to have you here.

My first question is quite general. Do we have a tendency to develop healthcare policy in an urban-led way and, if so, why does that cause a problem in healthcare in more remote and rural areas?

Dr Stephen Makin (NHS Highland): I completely agree that we have a tendency to develop healthcare for urban areas, and there are a number of reasons for that. It is largely because, when we are developing healthcare interventions, it is usually done by clinical academics who are based at universities and who, with the exception of me, I think, work in big urban hospitals, and there is a tendency to forget that healthcare has to be delivered differently in a rural hospital.

I am a geriatrician, and my sub-specialty is stroke. We are struggling to deliver thrombectomies in rural areas because, when that service was developed and the evidence was developed, it was all done in big urban centres. Just thinking of the basics, I practise in Caithness, and the nearest place where a thrombectomy can be done is Dundee, and it has to be done in six hours. How do we even select the right patients to go to Dundee and when? We are operating in an almost evidence-free zone.

When it comes to solutions, as a clinical academic who has worked in a rural area, I try to stay involved and get involved in trials. I am often the one who puts his hand up to various proposals and says, "That's not going to work in a rural area." It contributes to inequality because,

sometimes, I feel that the evidence is from a different planet.

Carol Mochan: Thank you. Would Dr Makin or Professor Smith have anything to add to that?

Professor Annetta Smith (University of the Highlands and Islands): I completely agree with Dr Makin. Every part of the patient's journey from diagnosis to treatment to accessibility of treatment is affected by the context in which the patient is situated. Even in a rural area, that context—for example whether it is remote rural or island—differs. Although some patients are living in rural areas, their access to hospital care can be quite efficient. For others who live a distance from that hospital in the same rural area, the experience can be different. Although there are differences between urban and rural contexts, there are also differences in remote rural and island contexts. That is why it is vital that clinicians who deliver care and patients who receive care in those areas are part of the policy making and decisions and modelling for what will happen.

Carol Mochan: Dr Makin has indicated that she wants to come in.

Dr Rebecah MacGilleEathain (University of the Highlands and Islands): Hello. Sorry—I am Dr MacGilleEathain.

I agree with the other members of the panel. Our research in rural health at the UHI has identified the key issues that are needed in the work to support rural health and healthcare. Work is still needed to design and embed models of service delivery that overcome the disadvantages of geographical distance, as Professor Smith was saying about the issues of transport, transportation, access and availability.

We still have not overcome the challenges of recruitment and retention of the rural workforce, particularly the shortages of people choosing to enter rural general practice. There is still work to be done to integrate digital technology into rural healthcare delivery to ensure that it is acceptable to patients and healthcare providers.

Carol Mochan: Thank you. I apologise for mis-saying your name.

I am interested to know a wee bit about the research community, because it was touched on. Are there things that we can do to make sure that research happens in rural areas, or is it about being connected with research as it happens and making sure that rural areas are involved in that?

Dr MacGilleEathain: It is a bit of both. There are issues with rural research being included in large studies and funded projects but also with funding to conduct rural research that involves going into rural areas and travelling long distances to meet and engage with communities. We have found in our research that it is so important that the communities and people who are affected by the decision making—healthcare providers, patients and community members—are involved in it. It is costly to conduct that research. It is about supporting the costs of that research which, unfortunately, can sometimes be higher than the costs in urban centres, given the distances that need to be travelled to speak to people in dispersed areas in Scotland.

Carol Mochan: That makes sense. Does anybody want to add to that?

Professor Smith: Any decisions that are made around clinical practice need to be based on good evidence, and I do not think that anyone would argue with that. What Dr MacGilleEathain said was right: it is important that we have the ability to conduct remote and rural research and that we have the resources to do that, so that we get to the heart of what communities want.

We also need to take account of existing research. There is a vast body of research on remote and rural practice. There is a lot of international research that we should take notice of. There are a lot of innovative solutions that others have used that we could also consider. It is about looking at the existing research base but also, as Dr MacGilleEathain said, ensuring that, when decisions are made, we are able to access local communities to further that evidence base and see what is best for them.

Carol Mochan: Thank you.

The Convener: I have a supplementary question for Professor Smith. You mentioned that there is international research, and I am thinking of other countries that have remote communities, such as Australia and Canada. Are we using the research that has been done there for their rural and remote communities, or are we overlooking some of that?

Professor Smith: We do not use it as well as we could. In the context of looking at remote and rural areas, international research can be quite different. Sometimes, we have more in common with, for example, Scandinavian countries than we do with some other remote and rural areas, but there are excellent models that we could learn from. As an example, extensive work has been done in northern Ontario with the medical school on the ability to recruit local people to train as doctors so that they remain working and living in the areas in which they train in northern Ontario. That is one example, but there are plenty of examples of innovative solutions to workforce and healthcare delivery that we could really learn from.

David Torrance (Kirkcaldy) (SNP): Good morning. You touched on this in one of your answers: how important a role should community

engagement and co-production play in the development of rural health services? What are the benefits?

Dr MacGilleEathain: We have seen in our research on rural health at UHI that it is extremely important. Co-design is so important for the development of rural healthcare services, with community members and local healthcare professionals being involved. It is important to understand their viewpoints and for them to have an opinion and be involved in the design of services that people find acceptable and affordable. We found from the being here project, in which we designed primary care models in several Highland communities, that that was very important.

We also found from a literature review that the ethos of that sort of engagement is as important as the particular methods that are used. That sort of engagement needs to be done in a way that ensures that the community feels supported and listened to. People in the community have to have ownership and appropriate representation so that the design of healthcare is being done not to them but with them, working with them. That has been highlighted across all the types of research that we do in rural health.

David Torrance: How can we strengthen the examples that are in place, and what good examples are there that we could share across the rest of Scotland?

Professor Smith: As well as engagement with the local community through research, as Dr MacGilleEathain has just outlined, there are good structures in place in communities that ensure that communities are actively involved in planning. For example, local planning groups are active throughout some remote and rural communities. It is also vital to include the third sector in that engagement, as it is very much a partner in care delivery. When we are looking at community engagement, we need to look at it in its broadest sense through formal, informal and research opportunities.

Dr Makin: I agree with what the other witnesses have said. If you design a new service without community engagement, it is unlikely to be valued or to meet the needs of the community. There are numerous examples of well-designed services with community engagement, and of poorly designed services without it. It is an essential part.

Ruth Maguire (Cunninghame South) (SNP): I will put a brief supplementary question to Professor Smith, who is a board member at NHS Eileanan Siar this year. It is good to hear about the principles, but if there were a specific example from the Western Isles that would add a bit of colour to our discussion, that would be helpful.

Professor Smith: I am thinking about the re-engagement of local planning groups. Post-Covid, the local planning groups—not all of them but some of them—are starting to re-engage. Dr Makin will probably come in with an example.

09:30

Dr Makin: I am sure that there have been many examples in your health board. In Highland, I can think of two examples in Caithness, one where it has gone well and one where it could have gone better.

The local maternity service at Caithness general hospital, which is a two-and-a-half-hour drive from Inverness, was downgraded to a midwife-led unit around 2016 without any consultation, largely because of concerns about the immediate safety of babies. There was not a lot of consultation with the community about the fact that NHS Highland felt that it could not provide a safe consultant-led service. There is still a lot of resentment and anger in the community, which is justifiable, given mothers' experiences of having to drive for two and a half hours while in labour. I have never had a baby, but I suspect that that would not be an easy thing to do. It was difficult, because there was a degree of urgency there because of patient safety issues, but we could have engaged more in explaining to the community what the difficulties were and looking at the options.

We have recently redesigned services for older people with a lot more community engagement. That has gone much better, and the proposed model of service of a community hub for intermediate care is being valued, I believe, as a valuable service that people want to engage with. Although we are moving services from the acute hospital to the community, it is not being seen as bed closures; it is being seen as the opening of a new service, which it is, although we are reducing the number of acute hospital beds by two.

I suspect that involving the community in the dilemma that is presented by the problems with the existing service would have been helpful in the first example.

Ruth Maguire: I am aware of the first example, and I think that it is slightly different when we are talking about safety concerns, so shall we move to the other one, where you said that there was good practice? You said that there was engagement with the community. What did that look like? Who did the health board speak to? How did it do it?

Dr Makin: It has been a long process, and it started before I joined in 2019. There is the local health action team, which is a pressure group that we really engage with. At the very early stages, there was a series of events to design the service, and that was before the appointment of

contractors or consultants on the design and specification. There were representatives from almost every local community group that we could think of. It felt like almost everyone was there. The local health pressure group was certainly there, as were the voluntary groups, the local council and care agencies, but charities and third sector groups were also represented. It felt like everyone had a voice there.

The service was designed from a basic level at those events. We asked what we wanted from a service, where things should be delivered and what "good" would look like. It was about two years before we even appointed an architect or had a term of specification for the service. It did not feel tokenistic at all.

Ruth Maguire: Had the decision to move the services to a community-based setting already been taken and this was about designing what they looked like, or was it the public's input that led to it? Which way round was it?

Dr Makin: I will be honest and say that the initial decision happened two or three years before I joined the health board. Shortly after the decision on the maternity service, there was a top-down decision to move services to a community-based setting. There were protests in the street, I think, as a result of that, so the health board stopped that and looked at service redesign.

As part of that, it gave a presentation about the unsustainability of the current service model and why it felt that it could not be sustained, and, during the consultation, it emerged that there were far better service models. We were delivering services in hospitals that could be delivered in people's homes and, when that was put to people, no one wanted to be in hospital when they could be at home. The mutual feeling was that it could be better.

No, I do not think that the initial plan to move services to a community setting was made in a top-down way with no consultation and this was a reaction to that.

Ruth Maguire: Thank you. That is helpful.

The Convener: I have a brief supplementary question. Dr Makin, you spoke about co-production, community engagement and redesign of services, but this question is not just for you specifically. What is the difference between redesigning services in a remote rural setting and doing that in an urban setting?

Dr Makin: I will be honest and say that I have never designed a service in an urban setting. I suspect that it is easier in a remote rural setting because, although you cannot always get everyone in one room, the community is a bit more connected. I suspect that, with a more connected community, it is easier to identify the people who need to be invited, but I am interested in hearing the other witnesses' views.

Dr MacGilleEathain: It goes back to the issue that we touched on of taking an urban model and trying to apply it in a rural area. The understanding and experiences of healthcare and of accessing healthcare that people who live in more remote rural areas have can be very different from those of people in urban settings. That might be the urban and rural divide. To get people to engage, we need to understand what works for them. We should not think that taking a model from urban areas and applying it in a rural area will necessarily work.

We should understand why that is the case. We have done some work that has highlighted that rural residents are concerned about what they perceive as a lack of mental health services. We used community engagement methods and a consensus-building exercise to assess rural mental health needs in the Western Isles and the Black Isle. When thinking about how they would access services, residents recognised a need for preventative, place-based and integrated national health service and third sector mental health services that would work for them in their local area and in their geographical area.

That is an important aspect of service design when we look at the difference between rural and urban settings. A lot of it has to do with geographical distances and the availability of services. In urban settings, there might be much more availability, and if somebody does not want to go to a particular place, they have the choice to go somewhere else, whereas, in more remote rural areas, that is not always the case, because only one service—if that, in some cases—is accessible.

The Convener: Thank you.

Ruth Maguire: Dr MacGilleEathain, I would like to hear a bit more about the work that you did on mental health services, because one theme in the responses to the committee related to mental health and addiction services. People spoke about their concerns about the lack of availability of such services, as you said. Issues relating to waiting lists and access were raised in a number of submissions.

People also spoke about health inequalities and deprivation, which are common across the country. You talked about the services that people are looking for in rural areas, but people in urban areas would also very much appreciate preventative community-based services.

You spoke about the model that you used when engaging with a community and said that you had done a "consensus-building exercise". Can you

speak a bit more about that so that we can understand what happened?

Dr MacGilleEathain: Yes. My colleague, who could not be here today, conducted that research, so I cannot provide the full details, but it involved a consensus-building exercise using a modified Delphi method. Basically, you use some statements that people disagree with and others that people agree with, and you keep going around in order to see what people agree with the most. You gain consensus that way. People can also rank their priorities, and you then keep going around in a circular mode with community members to find out whether there is consensus.

We have found that to be an effective way in which to understand the views of healthcare providers and of patients and community groups. Sometimes, their priorities can differ—patients' priorities can be very different from healthcare providers' priorities—but being in groups and visualising one another's opinions can help to build consensus in those areas. I hope that that makes sense.

Ruth Maguire: It absolutely does. Did you say that that work was done on the Black Isle?

Dr MacGilleEathain: Yes—and in the Western Isles.

Ruth Maguire: How did the health board respond to that work? Was there any change in services for the citizens who live there?

Dr MacGilleEathain: I could not tell you. It is fairly recent work, and I am not sure whether any changes have been made as a result of it.

Ruth Maguire: Okay. Some respondents highlighted that a whole-system approach to policy action is necessary. What is a "whole-system approach" and how could it be used to the benefit of people living in rural areas?

Professor Smith: I can speak to that and give an example. Throughout the Highlands and Islands, the most pressing issue is recruitment and retention of healthcare and social care staff. It is more acute in some places than it is in others, but it is pretty concerning everywhere.

Perhaps it is easier if I just give the example of how a whole-system approach would work in the Western Isles. Recruitment difficulties are tied up not just with the availability of health and social care professionals but with the infrastructure that supports people to live and work in the Western Isles. That includes everything from schooling and wraparound childcare to transport, accessibility, the cost of living, digital structures and connectivity. All those challenges have been extremely well rehearsed, so we know what they are. They are key considerations for health boards and councils.

In relation to the recruitment of health and social care staff, the issue relates not just to the availability of staff but to how they live, work and thrive in the Western Isles and to whether the structures to support that are there. If they are not, people simply will not come, because they can choose to go where they will have readier access to services. We can try as hard as possible to recruit staff, but, if the social structures are not there to support people to live and work on the islands, staff will not come. That is one example of the need for a whole-system approach. Things cannot be addressed in isolation; the whole context has to be considered.

Ruth Maguire: I suppose that, in the Highlands, housing will play a big part.

Professor Smith: Yes, it certainly will.

Ruth Maguire: Is any work going on to address those matters? What work is being done by the health board and the local authority?

Professor Smith: A lot of work has been done on mapping the population. As, I am sure, many members of the committee know, there is a significant concern about depopulation. The demographic differences in the Western Isles, for example, are starker than they are in other remote rural areas, although they are also an issue in those areas. The islands cannot address depopulation themselves; that needs to be done in partnership with the Scottish and United Kingdom Governments.

Ruth Maguire: Thank you.

09:45

Paul Sweeney (Glasgow) (Lab): I thank the witnesses for their contributions so far. I want to pick up on the issue of service levels. The child and adolescent mental health services target is for 90 per cent of patients to be seen within 18 weeks of referral, but that target has never been met nationally. Dr MacGilleEathain, do you have any insights into what waiting times in Scotland are like in rural areas vis-à-vis urban areas?

Dr MacGilleEathain: I do not have the figures on waiting times for CAMHS, but I know that there are significant waiting times in NHS Highland for CAMHS and that that issue has been repeatedly highlighted by service providers and by young people and their families. I do not know the figures for urban and rural areas off the top of my head.

Paul Sweeney: No problem. Dr Makin, do you have any helpful insights?

Dr Makin: Unfortunately, I do not have the figures to hand, and I could not easily find them by googling while Dr MacGilleEathain was speaking.

Paul Sweeney: No problem.

Dr Makin: You have to look more broadly than just at waiting times, because, if there is no service available, there will be no waiting list for it. I know that that sounds stupid, but there are many instances in which the service that can be offered is not accessible so people are not referred to it. If people on an island would have to travel to the mainland to get an operation, they might elect not to have it because they do not want to travel or the travel is not accessible, so looking only at waiting times masks that situation.

I am sorry to always drag the discussion back to Caithness, but, in some rural areas, we do not have any care-at-home services available. Given that people know that no care-at-home services are available, my patients do not always request such a service and, instead, choose to go straight into a care home. I have had to start asking my team to record requests for a care-at-home service so that we have a waiting list and people can see the need for it. If a service is not accessible, there will not be referrals, so you will not necessarily see a waiting list.

Paul Sweeney: Are you aware of any geographic deserts with regard to CAMHS provision in rural settings in Scotland?

Dr Makin: As a geriatrician, I am not, because I do not treat children.

Paul Sweeney: Fair enough. I just thought that you might have had a general insight.

Dr Makin: One of the other witnesses might be able to say more.

Paul Sweeney: Professor Smith, do you have any insights on CAMHS provision in rural settings?

Professor Smith: No, there is nothing that I can add to what has already been said. I do not have ready access to the figures, although we know that demand exceeds supply.

Paul Sweeney: Okay. The issue of health inequalities has come up a lot during the consultation process, and we know that people from areas of high deprivation have poorer health outcomes but are less likely to accept offers of care and engage with health services. Do the witnesses have a view on how we reach those people and address health inequalities in rural areas specifically?

Professor Smith: Dr Makin gave a good example when he talked about community engagement in Caithness. Again, we need to take a whole-system approach in order to encourage community engagement. The difficulty is that there will always be people who are harder to reach and are less likely to engage with, for example, preventative care. It is about coming up with ideas and solutions that will ensure that people who are less likely to seek help are supported to do so.

Paul Sweeney: Dr Makin, have you any insights into that? Obviously, your work with geriatric patients will show the consequences of inequalities over a lifetime. Do you see that starkly in rural settings?

Dr Makin: [*Inaudible*.]—a little more starkly there. In rural settings, it is important that, when we come up with a new model of service, we do a thorough equality impact assessment. Again, examples can help. NHS Near Me is a great service for video consultations, but someone in a rural area needs to have expensive broadband to be able to access it at home. They need to have fibre optic broadband. I am talking to you from a house that does not have fibre optic broadband; I pay £50 a month to get mobile broadband. When I try to do a video clinic, the broadband that most of my patients have is not good enough for a video call, so we just end up talking on the phone, which negates the whole point of the service—it is not the same. By moving our service to video calls, we are exacerbating socioeconomic inequalities. We are reducing them in other ways for people who cannot travel, but I do not know whether an equality impact assessment would pick that up.

Paul Sweeney: Professor MacGilleEathain, would you like to come in?

Dr MacGilleEathain: Thank you—you have just upgraded me to professor. [*Laughter*.]

Paul Sweeney: Sorry.

Dr MacGilleEathain: I want to speak about inequalities and about the mixed-methods research that we did this year with younger people in the Western Isles on the interconnection between reproductive and sexual health and wellbeing and mental wellbeing. We identified that adolescents who live in remote, rural and island communities require further support and that LGBTQIA+ young people are more likely to express that need. The study identified that the intersectionality of being LGBT+ and residing in a remote rural area might increase someone's experience of inequality in accessing health and wellbeing support, including mental wellbeing support. For example, 68 per cent of young people in the study said that they had witnessed LGBT+ bullying, and the figure increased to 86 per cent for those who identified as LGBTQIA+. Fears of judgment and stigma from the local community and a lack of anonymity and availability can inhibit access to health protective behaviours and support.

The study looked at health inequity and identified a real need for place-based health and wellbeing support for young islanders in particular. That support should be co-produced with the young people living in the local and social context

to enable them to counteract the health inequity that they experience.

Paul Sweeney: That is a really helpful insight. Thank you very much.

Gillian Mackay (Central Scotland) (Green): Good morning. What impact is the ageing population currently having on healthcare services in remote and rural areas? As the ageing population increases, how is it likely to continue to affect services? I ask Dr Makin first.

Dr Makin: Obviously, the ageing population is having a profound effect on services. Our core customer base—if we are providing customer service—is older people. Some 80 per cent of our in-patients are older, and those people need healthcare.

There are a number of challenges. One is that it is not just that numbers of older people in rural areas are increasing; there is also a decrease in the number of younger people. If your family are 500 miles away, they cannot help when you need help. If there are no jobs for younger people but the older people stay, there is no one to look after them. Often, the person's family are not near them, so they are more likely to stay in hospital as a delayed discharge after a minor illness.

That situation, of people having no family to help them, is exacerbated by incoming retirees, who contribute a lot to the community—although I will quote a relative of one of my patients. They said, "You moved 600 miles away, mum. I can't drop everything every time you get sick." When people move away from their family and social network and become ill, they often need more health and social care services to recover. If the incoming retirees have increased the house prices—[*Interruption*.]

I am sorry; my dog is having its say. Shut up! This is embarrassing!

If the incoming retirees have increased the house prices and younger people are not able to stay in the area, who will care for them?

Gillian Mackay: Do any of the other panel members want to come in on that, before I move on?

Professor Smith: I would like to mention one more thing. Older people are the greatest consumers of health and social care, so as absolute numbers increase, there will be increased pressure on health services and budgets. Budget allocations do not necessarily take account of patient profiles or of numbers. Where the demographics are that there is a greater number of older people than of younger people in the population, those older people will consume much more of the health and social care budget.

We know about the difficulties that are associated with availability of health and social care workers to support older people in remote and rural areas—Dr Makin has alluded to that. There are also the fundamentals of how we resource that increasing requirement to support older people in health and social care settings to consider.

Gillian Mackay: Thank you.

In designing services, what do we need to do now in order to address the ageing population, and what barriers are there currently to designing services that would meet the needs of older people in remote and rural areas? I ask Dr Makin first.

Dr Makin: Thank you—[*Interruption.*] Ssh! The dog is a therapy dog in a local care home.

In designing services, it needs to be acknowledged that it costs more to provide services in rural areas. I know that it sounds stupid to say it and it might be obvious, but that is not always reflected in the funding model. Providing services in rural areas will cost more because travel times, for instance, have to be covered, or you have to come up with a new model that does not work in quite the same way.

An obvious barrier in setting up a community engagement event in a town is that housebound people from the local villages will not be able to come to it. You have to really work with people and know your community to work out who the core users will be, and you have to go to them. It is actually a little easier in rural areas to identify the core people—to work out who will use the service and to make sure that they come along. Too often in community engagement the same faces come to every event, whatever service we are discussing. They put a lot of time and effort in, and we value their contribution, but we might need to be a bit more proactive.

Gillian Mackay: That is great. Thank you. I think Dr MacGilleEathain wants to come in.

Dr MacGilleEathain: I want to mention an evaluation that we did recently about ageing well, and non-pharmaceutical interventions that are linked to social prescribing dimensions, and the social dimensions of health. We conducted an evaluation of technology-enabled social prescribing for rural older people in Scotland, Ireland and Northern Ireland. It identified that the format is particularly effective in improving patient-reported outcome measures for people with depression, and people with chronic pain and chronic kidney disease, which might both be related to depressive symptoms. The format had the least effect in relation to people with frailty and dementia. However, in the evaluation, 60 per cent of people with depression had decreased levels of

loneliness after social prescribing, and 48 per cent said that their life satisfaction had increased. We have a full report on technology-enabled social prescribing, if the committee is interested in that.

10:00

We are also doing work at UHI on rural health to evaluate the community link worker social-prescribing model in NHS Highland. Alongside other variables, that work is collecting demographic information on the population who are taking up the social-prescribing service, and information on how it translates into more rural and remote settings. We know that it has been positively evaluated in more urban settings; we are looking at how it might support the ageing population in remote and rural areas. The initial findings of that research are expected in July 2024.

Gillian Mackay: That is really useful. Thank you. If any of those pieces of work that you referenced could be sent to the committee, we would be really grateful.

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

I will ask about technology and digital services. We touched on the matter slightly in comments on the potential to exacerbate inequalities, but I will focus on understanding what role new and emerging technologies can play in providing support in the rural environment. The need for those technologies is probably greater in that environment, which gives the potential for them to be rolled out more rapidly in the remote and rural areas. What do you see happening with those technologies, and what else can be done to roll them out further? I am asking about digital connectivity, but also about medicines delivery by drones, sensor technology in homes and any other technologies that you might be aware of that are in use.

Who wants to come in first?

Professor Smith: I can make a start, although this is not necessarily my area of expertise.

The role of technology in remote and rural areas is undisputed. It can be used to enhance services, but it cannot always be used to replace them, which is important to remember. It feels as if we are on the cusp of a technological revolution in supporting people to live at home and in delivery of medical care. We have already mentioned the importance of technology to the whole-system approach. It is good that it is there; it is developing and the possibilities in what it can do are exciting.

Infrastructure, broadband speed and network coverage have to be in place first, however. It is quite difficult when exciting things are promised but are not deliverable because of reasons that we know. We have talked a lot about older people living in remote and rural areas. We know that they are less likely to use technology, and that access to it decreases with age.

I want to mention something that I have been thinking about for quite a while. Some of the terms that we use around technology and the possibilities of technology are not always seen as positive. For example, we talk about “remote medicine”. For me, as a clinician and an academic, the possibilities of remote medicine are exciting and will mean that people can access expert clinical opinion without necessarily having to travel, but the whole concept of remote medicine is sometimes seen as a negative. I would like remote medicine to be called “accessible medicine”. I do not want to feel that I am remote from my clinician; I want to feel that I am accessible to my clinician. When it comes to public perception, the terminology that we use to describe the technology could be reconsidered so that the technology is seen as advantageous rather than as something that accentuates the distance between the person and the healthcare professionals.

Ivan McKee: Thank you. That is helpful. The point about people seeing things in a more positive light is well made. Our saying that remote and rural communities have been at the forefront in adopting the technology, which is then rolled out more widely, is helpful.

Does anyone else want to come in?

Dr Makin: I am wondering whether Dr MacGilleEathain wants to come in.

Dr MacGilleEathain: I am sorry—I had trouble unmuting myself.

I want to talk about a bit of work that we did with NHS Highland on the technology-enabled care pathfinder project on respiratory pathways that use digital approaches. We found that digital approaches can help to tackle the root causes and address important issues that have been identified. The data, however, needs to be in the right place at the right time for that. Data is not always successfully shared between different parts of the healthcare system—between primary and secondary care—and is not always accessible to patients, who want to be able to access information online in one digital place. They do not want to have to go to different places; they want one place where they can access their support and their own information.

Enhanced patient experience can also come from healthcare staff who are themselves more confident and informed about using the technologies. That is really important in respect of digitally enabled formats.

We did some work on use of videoconferencing consultations—Dr Makin talked about the Near Me system in remote communities—and on digital service design, with communities in Skye. That work identified again the importance of co-production of digital service design in remote areas. Members of the public identified issues with and provided insights on how the community could use Near Me at home. Had we not done that work with the community, those insights would have been unknown.

The patients and public hold unique perspectives when it comes to accessing digital health services and designing them to fit into communities. The work that we did with people on Skye showed that some people were able to access the service from home. Others, rather than doing it at home, went to a healthcare clinic, their local general practice or, sometimes, a community centre or their local public library—in really remote places, those things are sometimes all in one place anyway—to access their online Near Me appointment. People who had problems with technology or did not have broadband could access care by sitting in a room in a local community place. If they had problems, somebody was on hand to help them with access. That was seen as quite an effective way for community members to use the digital service.

Ivan McKee: I will explore that a wee bit further; it came up earlier in the session. Redesign of service delivery in remote and rural settings is, through necessity, perhaps more advanced than it might be elsewhere.

To what extent do you feel that remote and rural health boards are leading the way, through technology or service redesign, with processes that are then adopted elsewhere? Is that part of how things are developing, or not really?

Do you feel that, as remote and rural areas, you are at the back of the queue, or that you are, in certain areas, at the front because you are developing technologies and processes in advance of anywhere else?

Dr MacGilleEathain: In some respects, such as the Near Me project in Skye, I feel as though we are more at the front of the queue, but in other areas, it is a bit of both. There is important learning and so much potential for use of digital and accessible technologies in those areas, on which we could lead the way.

Ivan McKee: That is great—thank you.

Dr Makin, do you want to come back in?

Dr Makin: Sure. I too was going to cite the example of Near Me.

Another part of the answer was mentioned in a previous question. If a technology is co-produced and implemented well, it is likely to be accessible. One of the reasons why Near Me was a success was that it was heavily co-produced.

Although people without broadband could not access the service during Covid, people can now go to their local health centre and use the Near Me room, so it is more accessible. If something is co-produced properly, it is likely to be accessible, because the community will have raised those issues.

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

I want to pick up on Dr Makin's point about the limitations of consultations that use digital devices, because of the lack of fibre broadband or high-bandwidth broadband provision. Dr Makin said that that potentially worsens health inequalities, in that people on low incomes are less likely to be able to afford the premium broadband service that is required.

Is some intervention required, from a healthcare perspective, to make enhanced broadband services temporarily available to those who experience difficulty connecting and who require a more intense face-to-face digital connection? Is there some mechanism that you think might be useful to make available a high-quality satellite broadband service to people who find it challenging, in particular in rural areas?

Dr Makin: Improved rural broadband would be useful for many reasons, not least because it would improve access to remote employment, which would improve the health of many people.

In NHS Highland, people who do not have broadband have the option to access video consultations at their local health centre. I do not know how many people cannot access those—[*Inaudible.*]—limited. If the technology were there to improve broadband for a short time for someone who could not go out and who needed, say, an intense period of mental health treatment that could not otherwise be provided remotely, that could be useful in that and other settings.

I am thinking in particular of child and adolescent mental health services. I heard from a friend whose child tried to access CAMHS but who, I am afraid to say, did not do so, because they found travelling a long distance for group therapy difficult. If that therapy were being offered remotely and someone did not have the best broadband, perhaps improved broadband could be offered in the short term. I do not know how that would be done technologically.

Paul Sweeney: Neither do I, but the concept may be worth exploring further. Thank you for that helpful insight.

We have discussed good practice, but a recurring theme is that pockets of good practice are not necessarily scaled up well across the service. Do you have any insights into the institutional barriers to capturing good practice and trying to scale it up across a wider territory?

Dr Makin, as you have just spoken, one of your colleagues may want to come in initially if they have any thoughts on that; I can always come back to you.

Anyone should feel free to chip in with a thought on it.

As no one else wants to come in, I go back to Dr Makin.

Dr Makin: The main barrier is that, although pockets of good practice can be developed by a small group of enthusiasts without a lot of funding, scaling that up can be more challenging, because the funding environment is difficult. Often, pockets of good practice are created by enthusiasts without any specific funding for that work.

Dr MacGilleEathain may want to come in on that.

Dr MacGilleEathain: A lot of the work in the pockets of good practice is conducted by the third sector, not the NHS. There are a lot of good third-sector organisations that are supporting people's health, so we in the NHS do not necessarily always know what is going on. That is one of the issues: it is about finding out what they are doing, perhaps through word of mouth. Rural and remote communities work like that sometimes. We may find out that there is a good third sector organisation that is supporting people's health well and has a really good model, so we need to investigate and understand how that works, and take learning from it. Sometimes it can be bit of a barrier if the organisation is from the third sector rather than the NHS.

10:15

Young people in particular can access different models in the health boards across rural and remote areas, so there is not always across-the-board equity for them. Some young people in certain areas of rural and remote Scotland can access services for mental wellbeing and sexual health, for instance, much more easily than young people in other such areas. That seems to be an issue where there is not a set of guidelines or evidence-based practice to support provision. That should be investigated in order to support the health and wellbeing of certain sections of the remote and rural population.

Paul Sweeney: Are you talking about headhunters in the NHS going around and looking for pockets of best practice and opportunities to scale up? I do not mean angel investors exactly, but people who go around trying to identify opportunities and how they can be benchmarked and brought into the service on a broader basis. Is that what you are saying?

Dr MacGilleEathain: Possibly, but I am also talking about working with communities and finding out what is most important for them. Usually, third sector organisations are very good at community development, and when they are doing it well, they normally have a very good model. We need to look at some of that and take learning from it.

The Convener: The committee has seen other submissions and heard from other panels about workforce shortages and difficulties in recruiting in remote and rural areas, so I am not going to ask you specifically about recruitment. However, I am keen to hear from you, as academics, about how you see training and learning opportunities for staff in remote and rural settings. Are those areas attracting people to come to, and live and work in, those communities?

Professor Smith may want to start on that.

Professor Smith: Workforce training and education, as well as the other things that we spoke about, are pivotal in attracting and retaining staff in remote and rural areas. There are many aspects to that. We need to ensure that healthcare professionals are not professionally isolated and that they maintain their skills, which are often more general than those that their urban counterparts use.

We also need to ensure that robust training and educational opportunities are available. It is also important to have clear professional progression opportunities for not only nurses, doctors and allied health professionals, but for the unregulated workforce, as that will give people opportunities to develop.

We have to capitalise—for want of a better word—on the population that we have that is working in health and social care. It is important that we provide development opportunities for those staff so that they will stay and work in the areas that they are in.

Locally accessible training is vital. I will give an example of how we can address training and education and recruitment opportunities. If we ensure that students who are in training have access to remote and rural placements so that they get a taste of what remote and rural healthcare is like, and if we make those placements as good as they can be and they are supported, it might increase the likelihood of attracting some of those professionals back to those areas. It is important to have students

access that experience and for them to have a taste of remote and rural practice.

Sometimes, we have to be a bit pragmatic about that. A healthcare professional may, after having that experience, come and work in a remote and rural area for two or three years rather than stay there for ever. We have to look, therefore, at how we maximise the opportunities through education, training and placements. If we make those the best that they can be, we can encourage people to work in remote and rural areas, rather than having them feel as though they are going to work in a backwater and that their professional career is going to stagnate. It needs to be the opposite: it has to be seen to be exciting professionally, with opportunity, education and training built in.

The Convener: Does anyone want to add to what Professor Smith has said on the subject?

Dr Makin: It is an area in which new technologies have made a big difference. I would not be able to appear before the committee today were it not for remote technology—I just could not do it. It is also a lot easier to stay in touch, and to work remotely and not be professionally isolated. I never thought that I could be a clinical academic and live and work in Wick.

My job came about because I was a clinical academic already and bought a holiday cottage here. One of the managers from NHS Highland tried to recruit me and then created an academic job for me, which involved a lot of creative thinking. It means that I am taking the lead on medical students and supervising PhDs; I hope that my coming from a teaching hospital and being in touch with the research community means that the students feel that they are not in a backwater but are getting up-to-date training.

Clinical academics are not the only solution to rural healthcare, but if we further embed clinical academics in remote and rural areas, and if more of us are willing to come to those areas, it could help a lot. It really helps with training. Simply being on a steering committee for a trial, if you are not in a teaching hospital, means that you can intervene and stop something being developed if it is totally unrealistic. Moreover, agreeing to fund or partly fund people's research sessions is a lot cheaper than paying a locum, and it also means that they stay.

As for trying to recruit clinical academics to rural areas, they got me to come here, and I hope that they will get other people, too.

Emma Harper (South Scotland) (SNP): Good morning. It has been interesting to listen to the discussion and to hear colleagues' questions. I am interested in looking at how the Government will develop policy in the future.

In preparing for this inquiry, I accessed loads of papers and research related to remote and rural healthcare, whether for adults, children or maternity services. I have in front of me a 2007 report from the remote and rural steering group. There have been discussions with Lewis Ritchie, there have been Derek Feeley papers and I remember Jason Leitch talking about the Nuka healthcare system in Alaska being used to develop rural healthcare in Scotland—that was in 2000. We have been talking about how we deliver healthcare in remote and rural areas for decades now. I know that the issue is complicated; indeed, that is why so many policy papers have been discussed.

What current issues must the Scottish Government address in order to deliver remote and rural care? The situation has been challenging after Covid, but we learned from the pandemic when we immediately switched to the Near Me platform. I am interested in hearing your thoughts about current Government policy and what we need to do as a matter of urgency.

Professor Smith: Shall I go first? I will probably just reiterate what has already been said, but it is important.

I agree that much work has been done on remote and rural healthcare. Sometimes, though, we do not learn from what has been done. Social, personal and professional dimensions affect healthcare delivery, no matter whether you are a healthcare provider or a recipient of healthcare, and looking at some of the challenges in isolation just does not work.

We therefore need a whole-system approach to address many of the challenges in the delivery of healthcare, including the recruitment and retention of staff and innovation and development. For example, we were just talking about digital health; if there is no education element to digital health and if we do not ensure that the staff who use digital health solutions are adequately prepared and educated, it will not be as effective as it could be. A whole-system approach based on the needs of the population in remote and rural areas should be part of the policy making. I know that it is pretty complex, but we are talking about a social system, and if we pick off ideas and do not look at this as a whole, many of the solutions, which could be excellent, just will not work.

Emma Harper: Just to pick up on that suggestion of a whole-system approach, Professor Smith, I was reminded of some of the challenges that we have experienced in our local casework. For example, the bus from Stranraer to Dumfries doesnae have a toilet on it, and people have been feeding back to me that they avoid taking their diuretics on the way to hospital appointments, which they shouldnae be doing. At this point, I

remind everybody that I am a registered general nurse in Dumfries and Galloway, which is quite remote and rural in many places.

When you talk about a whole-system approach, it makes me think of that example: we have asked for a toilet, but the bus company or the regional transport partnership are not even on the integration joint board or part of the health and social care partnership. Obviously, part of the system is not connecting if people are having to avoid taking medicine on the bus, just because the journey might be two hours and there is no loo available. That is an example of how part of the system is not working right now.

Professor Smith: I agree. A lot of patients are not taking their diuretics before hospital appointments, because it takes them a long time to get to where they need to be.

I think that Dr MacGilleEathain wants to come in here.

Dr MacGilleEathain: I agree with the points that have been made. The infrastructure in remote and rural areas needs to be supported so that the healthcare workforce, patients and communities have access to what they need. Indeed, it is a dimension of supporting health and wellbeing in those communities.

The social dimensions of health are really important, and that is why redesign that is not afraid to break the mould by actively involving patients and front-line healthcare professionals is so important. The digital integration of data should allow data flow between primary and secondary care—and I am talking not just about VC appointments but about wider systems in digital healthcare—and we should recognise the importance of looking at underrepresented and marginalised communities in remote and rural areas who might be at increased risk of further health inequity because of where they live.

I agree with what Professor Smith has said about the whole-system approach. Instead of having little models for what is going well, important as they are, we need a whole-system approach to infrastructure in order to deliver good health and social care in those communities.

10:30

Emma Harper: Does the new national centre for remote and rural health and care need to have an advocacy role to address some of the challenges that people might have with their healthcare, no matter whether we are talking about adult, child or maternity services? I am interested in how we advocate for patients when they feed in to the system to ensure that the system reacts.

Professor Smith: In relation to the national centre, there needs to be a patient voice. If the centre is about addressing and finding solutions to health and social care problems in remote and rural areas, the patient's voice and the community voice will be absolutely central to that. Indeed, it was part of Professor Sir Lewis Ritchie's original report when the centre was proposed—it is absolutely crucial to the centre's success. After all, this is about not just the healthcare practitioners but remote and rural communities.

Sandesh Gulhane (Glasgow) (Con): Good morning, panel. I declare an interest as a practising NHS GP.

I will start by asking about primary care, which is obviously a focus of mine. Dr MacGilleEathain mentioned the GP contract that was introduced by the Scottish Government. What did it do to rural primary care? Did it have a positive or negative effect?

Dr MacGilleEathain: I do not know whether I can speak for the whole of rural primary care, but I know that there have been positives and negatives. The contract took away some of the specific things that GPs used to do, and it created local centralised rooms where people could get their vaccinations, dressings and wound care. That might work well in urban settings where there are lots of healthcare centres, but that method and model of care provision does not work quite so well in rural and remote areas. Somebody who is elderly and lives rurally will go to their GP on the bus that comes once a week to get their flu vaccination, a wound dressed and such things; having a more centralised location for such patients is perhaps not the most useful thing for patient outcomes, as they might now have to travel to Inverness for their vaccinations instead of staying in their local area.

Also, for patients who have more chaotic lives and want opportunistic vaccinations or for parents who want to get their young children or baby vaccinated, a trip to the GP in their local area could be more accessible than going to some specifically designated room.

As I have said, we are evaluating the community link workers scheme that has been rolled out in Highland. Hopefully, we will have more information about that next year. That is as much as I can tell you about the GP contract in rural areas.

Dr Makin: I am not a GP, but I am friends with GPs, I go to the GP cluster meeting and I work closely with them. I do not think that the current rural GP contract has been well received by our local GPs. Certainly, the loss of vaccinations has not worked well in Highland in remote areas. With regard to logistics, we have heard of people driving for three hours to get one vaccination. You

cannot centralise things when the centre is 200 miles away; it does not work. I am aware that rural GPs do not feel that the contract works for them, and I know the British Medical Association GP committee's view, but there are many organisations that can speak for rural GPs better than I can.

Sandesh Gulhane: You have made an interesting point, Dr Makin. I have been told of rural patients who decided not to get their children's measles vaccinations because it meant a three-hour round trip and, quite frankly, they did not see anyone, so they just said, "What's the point?" It terrifies me that we are not getting measles vaccinations done.

Another aspect of primary care that I have been looking at is the percentage change in income allocation under the new contract. In general, if you are in the urban belt, you have seen an increase in the amount of money that you get, while in more rural areas, that increase does not seem to have happened. It almost seems as though we are trying to promote general practice and primary care in urban settings. Admittedly, 80 per cent of the population live there, but a substantial proportion of people—20 per cent—live in rural areas. What do you propose that we do for primary care to make things better for people who live in rural areas? That question is open to anyone who would like to answer.

Professor Smith: It is important to consider the stability of GP practices in rural areas. My answer is simple: I would ask the GPs who deliver care in those areas about the most effective way of sustaining services.

Sandesh Gulhane: Dr Makin, I see that you want to come in, too.

Dr Makin: My colleague in the local Caithness hub might say that the easy win would be to let them do the vaccinations again, as they were doing them cheaper and better than NHS Highland was. Obviously, though, there is far more to it than that.

Sandesh Gulhane: It seems that not very much money is being offered to GPs for that, which makes it difficult for them to do.

You mentioned Highland, Dr Makin, and I would just note that there has been a big report on bullying at NHS Highland. I am not going to talk about the Western Isles, Professor Smith, as I have not heard anything from there, but I have certainly heard about NHS Highland. How can we get better integrated rural healthcare, given the endemic culture that the report found in that health board?

In your answer to my question about primary care, you talked about those who are on the ground getting things done. I assume that the approach will be similar in secondary care, but how will we move forward in that respect, given the issues that have been highlighted?

Dr Makin: Having joined NHS Highland shortly after the report was published, I have noticed changes. There has been a big effort in the organisation to address the bullying culture; indeed, it has been addressed to such an extent that I do not recognise the organisation from the report.

That said, I go to our local GP cluster meetings—unofficially, I should say—and it can often feel like, when there is engagement with GPs on things at a higher policy level, GPs are being talked down to instead of being consulted by the board. The health board's view, certainly on the discussion about vaccinations, has been, "This is what we have to do—we do not have any choice. We know that it is not working." I do not know whether the approach was consulted on just in the central belt and now we are trying to roll it out and impose it on rural areas.

As for moving forward—[*Interruption*.]

Sandesh Gulhane: I am sorry—go on. I thought that you had finished.

Dr Makin: As for moving forward, a lot of the pressure on the health service from hospital in-patient care comes from the fact that we are the default social care provider in a crisis. At the moment, half the patients on my ward are delayed. I have 22 beds on my ward; there are 22 on the other ward; and I think that about a third of those patients are waiting for social care. That puts pressure on acute services, which, again, puts pressure on general practice. I do not know how much pressure is put on GPs from the lack of social care. They tell me that that happens, but I do not know whether it is the biggest pressure that they face.

If I could make one point, it would be this: we need to decide whether we provide social care or care at home to everyone or whether we should just tell people in certain areas that they cannot have it. If that is the case, we should be open about it. If you are thinking about retiring somewhere, should you be able to look at a map of the area to find out whether you can get social care? At the moment, you cannot do that. I appreciate, though, that that is a slightly different point to what you were asking about.

Sandesh Gulhane: Thank you very much. I have a final question, if I may. I want to touch on the thrombectomy services that you mentioned. We are still struggling to get thrombectomy services in Glasgow, which is a very urban area. I also want to go back to the issues that we are having with maternity services in Caithness being

downgraded and not being upgraded again, which you spoke of right at the beginning. I would like to hear from you, Dr Makin, if I may. You said that you are not a woman giving birth—that is true—but you must have spoken to patients who are worried about that. What pressures does the situation put on people in the area? What solutions could be put in place to help?

Dr Makin: You are right: I am not a pregnant woman, and, as the only man on the panel, I certainly do not want to speak over women, but, living in Caithness, I know that it puts a lot of stress on people. I am also aware of the issues with the former service. No one wants to go into labour after a healthy pregnancy, with the baby doing well, and leave hospital without the baby. That was the risk. The concern was that it was not safe.

On a personal level, when one of my colleague's wives was pregnant and he did not have a car, we sort of had a reverse on-call rota. If she went into labour, the consultant who was not on call would drive her to Inverness. Then we found somebody in Inverness with whom she could stay for a few weeks.

Delivering a consultant-led, all bells and whistles, safe maternity service in a rural general hospital will always be a challenge. As you know, there are five rural general hospitals, which have around 40 beds and no paediatrics. The island hospitals deliver a little more but at extremely high expense, but they do not have paediatrics. I have heard off the record how much Shetland spends on having an obstetrician available. I will not say what the figure is, but it is eye-watering.

If we are going to reintroduce full maternity services to rural general hospitals, should we accept that there is a risk to babies, or do we spend a vast amount of money? If we accept that the only way to have safe services is to centralise, women will have to be some distance away from their families during the later stages of their pregnancy.

It is difficult. At the moment, there is not a lot of support available for them. There is accommodation for a short period, but do we need to look at supporting women more if they will need to spend the last two weeks of their pregnancy in Inverness?

At the moment, it is all done socially. I have heard of mothers planning just to turn up to accident and emergency when their labour is too well established for them to be transferred. I am the consultant on call who would be resuscitating their baby—I am a geriatrician—and that terrifies me. I do not know whether they know that I have seen that; it was on the local Facebook group. I have even heard of women putting off having children because they do not want to face giving birth. If you are a single parent having your second child, who will look after your first if you have to stay in Inverness for two weeks? There is not really any arrangement for that. It is all done remotely, ad hoc and on the basis of networks.

10:45

We have a choice: do we accept a substandard service that could be dangerous, or do we make people uncomfortable by having them travel? I know that no one in NHS Highland wants to provide a substandard service. I worked in Cumbria around the time of the Kirkup report, and I have to say that the response of NHS Highland to the critical incident that led to the maternity service being withdrawn was exemplary. There was no effort to hide it, no cover-up, and the investigation was very open. That is certainly a world away from other areas, where maternity issues were not raised. The opinion of a geriatrician is largely irrelevant, but I think that NHS Highland should be praised for the open way in which it handled safety concerns. I have been reading online newspaper reports about maternity services investigations in England that have not been handled openly.

I do not know whether women are willing to accept a more dangerous service for the sake of convenience. The women who are willing are probably socioeconomically deprived and cannot afford access to a better, safer service. I would be keen for the women on the panel to offer an opinion.

The Convener: I thank the witnesses for their additional service to the committee in remaining online for 15 minutes. We are grateful for the evidence that you have given us today.

Subordinate Legislation

Food (Scotland) Act 2015 (Compliance Notices) Amendment Regulations 2023 (SSI 2023/161)

10:47

The Convener: Our next item is consideration of two negative instruments.

The first is the Food (Scotland) Act 2015 (Compliance Notices) Amendment Regulations 2023. The purpose of the regulations is to correct an error in the Food (Scotland) Act 2015 (Compliance Notices) Regulations 2023, specifically to substitute an incorrect reference to regulation 6(2) of the Novel Foods (Scotland) Regulations 2017 with a reference to regulation 4 of those regulations.

The policy note states that the correction

"will allow Authorised Officers (AOs) to use compliance notices to deal with breaches of the requirements in the Novel Foods (Scotland) Regulations 2017."

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 21 November 2023 and made no recommendations in relation to it. No motion to annul has been lodged.

Do members have any comments?

Ivan McKee: I do not have an issue with the substance of the legislation; it is more of a comment on process. Perhaps we could ask the clerks to do some background work on it. Clearly, the issue has arisen because there was an error in the drafting of the legislation. I am interested in getting more background information on how often that happens and on the process improvements that are looked at in order to reduce it. What is the process for finding such errors—how was this one found?—and what is the risk of them not being found in legislation that has already been considered? I would be grateful for any data that the clerks can pull together on that.

The Convener: I propose that the committee does not make any recommendation in relation to the negative instrument.

Members *indicated agreement.*

Feed Additives (Authorisations) (Scotland) Regulations 2023 [Draft]

The Convener: The second instrument for the committee to consider is the Feed Additives (Authorisations) (Scotland) Regulations 2023. The purpose of the instrument is to implement the decision made by the Minister for Public Health and Women's Health on 13 feed additive applications. It authorises the placing on the market and use in Scotland of 10 new feed additives, renews two authorisations with modifications and renews, modifies and authorises a new use for one other additive. The instrument also includes a transitional provision concerning an existing authorisation for one feed additive, which is renewed subject to a modification by the instrument.

The policy note states that the instrument

"aligns Scotland with England and Wales and with similar EU legislation for these feed additives."

It also states that Foods Standards Scotland and the Food Standards Agency have concluded that the feed additives

"as described in the applications are safe for the target species, users, consumers and the environment."

The Delegated Powers and Law Reform Committee considered the regulations at its meeting on 21 November 2023 and made no recommendations. No motion to annul has been lodged.

As there are no further comments, I propose that the committee does not make any recommendation in relation to the negative instrument.

Members *indicated agreement.*

The Convener: At our next meeting, we will continue our inquiry into healthcare in remote and rural areas, hearing from a panel of representatives of healthcare professionals operating in remote and rural areas. That concludes the public part of our meeting.

10:51

Meeting continued in private until 11:29.

This is the final edition of the *Official Report* of this meeting. It is part of the Scottish Parliament *Official Report* archive and has been sent for legal deposit.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba