OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 21 September 2021

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 21 September 2021

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

5th Meeting 2021, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

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

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Ross Barrow (Allied Health Professions Federation Scotland)
Professor Sir Harry Burns (University of Strathclyde)
Graeme Henderson (Scottish Association for Mental Health)
Professor Sir Michael Marmot (University College London)
Donald Morrison (British Dental Association)
Colin Poolman (Royal College of Nursing)
Dr Sue Robertson (British Medical Association)
Kate Seymour (MacMillan Cancer Support)
Professor Katherine Smith (University of Strathclyde)
Sue Webber (Lothian) (Con) (Committee Substitute)
Dr Vipin Zamvar (British Association of Physicians of Indian Origin)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 21 September 2021

[The Convener opened the meeting at 09:00]

Interests

The Convener (Gillian Martin): Welcome to the Health, Social Care and Sport Committee's fifth meeting in 2021. We have received apologies from Annie Wells. I welcome Sue Webber, who is attending in her absence.

Our first agenda item is to invite Sue Webber to declare any interests that are relevant to the committee.

Sue Webber (Lothian) (Con): I am a councillor at the City of Edinburgh Council and my salary is donated in full via the give-as-you-earn scheme. I own 100 per cent of the issued share capital of MEDinburgh Ltd, which was a company involved in healthcare sales and marketing. It was deregistered on Companies House at the weekend and has not traded since May 2021.

Decision on Taking Business in Private

09:00

The Convener: Our second item is a decision on whether to take items 6 to 9 in private, to consider the evidence heard in our stakeholder sessions this morning and to consider two legislative consent memorandums. Do members agree to take those items in private?

Members *indicated agreement.*

Public Health Stakeholder Session

09:01

The Convener: Our third and main agenda item is a round-table session with public health stakeholders that is intended to inform the committee's future work programme discussions.

I welcome Professor Sir Harry Burns, professor of practice and a special adviser at the University of Strathclyde; Professor Sir Michael Marmot, professor of epidemiology at University College London and director of University College London Institute of Health Equity; and Professor Katherine Smith, professor of public health policy at the University of Strathclyde.

I will kick off and set the agenda for the meeting. We have called on you all to help inform us on where the major themes lie in public health and where the committee might want to focus its efforts in relation to scrutiny and adding value to what the previous committee did. We also want to look at the landscape more generally to help us to prioritise our work programme. Your advice on that is greatly appreciated.

I will come to each professor in turn and ask where you think the committee should focus its efforts in our scrutiny of the public health agenda and where we might be able to add value. I turn to Professor Katherine Smith first.

Professor Katherine Smith (University of Strathclyde): My particular expertise is in understanding how previous policy approaches to addressing health inequalities have worked and what has shaped those policies, and in understanding public views on health inequalities in the United Kingdom.

My main recommendation is to focus scrutiny on ensuring that the policy making processes to tackle public health problems are properly joined up with the range of other policy areas that we know impact on public health or the social determinants. The Scottish Government has recognised that for a very long time in relation to things such as having—[*Inaudible*.]—and jobs that shape people's health, but it seems to have been difficult to join up policy making so that we think adequately about those links and how policy decisions in other areas impact on public health and vice versa.

There have been efforts recently on public health reforms in Scotland, but I would keep a close eye on those. Every time that such efforts do not work out well, we end up with what we call in public health a downstream drift, where even though policy makers know that what they are doing is not the most effective thing, they end up doing it because those are the policy levers over which they have control.

The Convener: I have a shout out for the broadcasting staff. Professor Smith's feed is quite jumpy. If we take off her video, would the sound, which is the most important part, improve? We were able to hear some of what she said, but the sound was quite jumpy. We will try to get that sorted out.

Professor Sir Michael Marmot (University College London): May I tell you a story about a mythical country that, for the purposes of this morning, I will call Norway? Some years ago, the Minister of Foreign Affairs there said, "I am a health minister, because what I do in my day job influences health. Every minister is a health minister, because what we do in our day jobs influences health."

Then I had a phone call from an official in the ministry of health in Norway whom I knew well, and she said, "You know how you've been going round the world saying that our Minister of Foreign Affairs says he's a health minister? He now is our health minister, and he'd like to meet you", so I went to Norway to meet him. He now is or will be Prime Minister Jonas Støre—I am not saying that correctly.

The message that I presume he will take to the Prime Minister's office is that what happens across the whole Government is key to public health, particularly for health inequalities. Yes, the healthcare system is important and yes, organised public health is important, but it is about what happens across the whole of Government. Indeed, in the "Build Back Fairer" report for England that I published in December 2020, and the one for Greater Manchester that I published in June 2021, I said that we need to put equity of health and wellbeing at the heart of all Government policy. In other words, it is a whole approach to health equity and to reducing health inequalities, and it should be at the heart of all Government policy.

There are discussions going on at this very moment about energy price rises because of a shortage of gas. I have heard little from Government ministers about the likely distributional impact of the prices. They will have a huge impact on health inequalities. If poor people have to pay more for their heating, and we have a cold winter, that will have an immediate impact on health inequality. Putting equity of health and wellbeing at the heart of all Government policy is key to public health and to reducing health inequalities.

Professor Sir Harry Burns (University of Strathclyde): I am very much in the same sort of seam as Sir Michael. When we talk about health,

we tend to think about illness and the absence of health as being ill. I was a surgeon for many years and I gave up surgery because I wanted to understand how we create wellness as opposed to tackling illness.

Sir Michael is absolutely right that it is a broad agenda. Creating wellbeing is what we would call a complex adaptive system. The problem with policy is that politicians like to do a thing. They make policies on fatty foods, on smoking or on alcohol and so on. In fact, we create wellbeing through a range of things that are not typically achieved through top-down policy. You can facilitate the creation of wellbeing by policy but, to a large extent, wellbeing is created in the relationships that people have with one another.

I speak a lot about the way in which wellbeing is created through early life, in the way in which children are born and raised and so on. Creating an environment that allows children to feel safe and happy and as if they have the opportunity to do well in life is really what I would want my Government to be doing and supporting.

I will give an example of a conversation that I had with one person, although I have had similar conversations with many people. The guy in question, who is currently working in a good job, started off his adult life in prison. When I spoke to him about his experiences, he said, "My mum and dad fought like cat and dog, and I would always get the blame for the fighting—it was always me who was in trouble. When I went to school, if there was any trouble there, I got the blame for it. When I was out on the streets with my mates, if anything happened, I would get the blame for it. I eventually ended up in jail."

What transformed that guy's life was a prison officer who took the time to talk to him every day and to tell him that he was better than that—that he was a clever guy who could do things in life. Building a trusting relationship with someone allowed him to begin to value himself. He now has a full-time job and is paying taxes. He is living well, with a family and children, but he helps other people who are in that position.

I would like to see a society where the politicians helped to support a bottom-up approach to improving wellbeing. It is important that they go out and ask front-line staff what people need rather than tell them what they are going to get. Politicians love a policy that they can fly a flag for, but I think that we ought to be building relationships that support people who live in difficult circumstances. There are lots of examples of organisations that do that, and we need to support them.

The Convener: That was helpful in enabling us to start to think about where our focus might lie. One theme that we want to ask you about is to do with life expectancy and the factors that are involved in that. Some of you have been involved in producing important reports on the subject. It is a hugely complex area, on which all of us have read many reports.

My colleagues have a number of questions on life expectancy. We will start with Evelyn Tweed.

Evelyn Tweed (Stirling) (SNP): My questions are about the moniker that Scotland has had as "the sick man of Europe". Does that moniker still apply to Scotland?

The Convener: To whom would you like to address that first?

Evelyn Tweed: Sir Harry, please.

Professor Burns: It is not a term that I have ever recognised or supported. There is no question but that inequalities began to widen dramatically in Scotland in around the 1950s, which was the time when industry was collapsing and housing policy shifted to the creation of new towns, where folk did not feel that they belonged. We can point to social drivers that created widening inequality in life expectancy.

However, it is unhelpful to label ourselves in those terms because, if folk are told that, they just shrug their shoulders and say, "Well, that's it—I'm going out for another beer. To hell with it!" That was the attitude in the conversations that I used to have with my patients, who would say, "Life's not worth living. The booze is the only pleasure I've got in life, so I'm just going to keep drinking." I heard people make that statement many times.

I do not think that we should label ourselves in that way. We can do a lot better, and we should begin to take action to improve things, but what action we should take is complex and not straightforward. It is not as straightforward as banning smoking in public places, which was important and a great step forward. Minimum pricing of alcohol has made a difference, too, but we need to get in and help people to feel more in control of their lives and to take positive decisions about their health. That is what we should focus on.

09:15

The Convener: Would any of the other panellists like to comment?

Professor Marmot: I am sorry—I did not hear the question very well. However, I heard Harry Burns very clearly, so I will guess the question from his response. Please tell me if I am wrong.

I am keen to work with Scottish colleagues, but we have been doing a lot of work in different parts of England. I can give you some statistics, but first

of all I should say that Scotland is like England in this respect, only more so.

If we look at life expectancy by level of deprivation in the areas where people live, we can see that there is a gradient, with the least deprived having the longest life expectancy and the most deprived the shortest. As for regional differences in England, we find that they are tiny for the least deprived; in other words, it does not matter much where you live if you are rich, and I guess that the same would apply to Scotland, too. The more deprived the area in which you live, the bigger the disadvantage of living in, say, the north-east or the north-west compared to London. In fact, in the decade since 2010, life expectancy for the poorest 10 per cent improved in London and went down in every other England region. Things got worse for the poor—their health declined.

With regard to the north-east and the north-west, you could, as Harry Burns described with regard to the deindustrialisation of Scotland, look at the situation there and say that it is hopeless. You could say that, for someone growing up north of the Tyne or in Cheshire, Merseyside or parts of Greater Manchester, things are hopeless and the future looks grim. However, people in those regions are not taking that approach. We have been invited to each of the places that I have mentioned. We have been to Cheshire and Merseyside; yesterday we launched a commission in Lancashire and south Cumbria; we did a report for Greater Manchester; and we have been approached by the North of Tyne Combined Authority. They are saying, "This is not hopeless. We can improve the quality of the lives of those who live in these regions. It has to be a partnership and we have to work together, but we are not starting with the assumption that this is all hopeless."

It is pretty grim to know that the health of poor people got worse over the past decade—indeed, it is quite an indictment of public policy—but the starting position is that things can be improved and a real difference can be made. It seems to me that that is absolutely right. In launching the commission yesterday evening in Lancashire and south Cumbria—a deprived area of the country with huge inequalities—we found that the starting position for local and regional government, the voluntary and community sector and business is, "We can make a real difference. We can work with our population to improve the quality of lives and health." That has to be the starting position in every region of Scotland, too.

The Convener: I ask Professor Smith to comment.

Professor Smith: Is the feed working better now?

The Convener: Yes, that is a lot better.

Professor Smith: I agree with a lot of what has been said. There are different ways of thinking about Scotland's relative performance on health and health inequalities. There are a lot of examples of places around Scotland to which we can look for inspiration, because things are going a bit better there; we can look at what people there have done. I would frame it in that way. The description of Scotland as the sick man of Europe is not a particularly helpful framing. Nonetheless, we need to recognise that there are issues that seem to be particularly bad in Scotland. Drug and alcohol-related deaths are particular issues on which Scotland needs to have a focus.

I support what my colleagues just articulated. A key issue is that we must think about how we have a public conversation about health inequalities, taking a bottom-up approach. We need to go beyond the voluntary sector and front-line services and have a conversation with members of the public about health inequalities and how we tackle them. That has been lacking from research into health inequalities. I am one of the few people I know who have tried to do research into what people think about health inequalities in the United Kingdom and Scotland. The research suggests that people are concerned about the issue and are supportive of policy proposals to tackle the social determinants of health, which should give us lots of reasons to be hopeful.

Gillian Mackay (Central Scotland) (Green): Do we need specific interventions in specific places or more system-wide interventions? For example, air pollution kills 2,500 Scots per year, according to Friends of the Earth Scotland. In my region, we have Scotland's biggest polluter. In our papers, there is a focus on Glasgow, which is a unique example in Scotland, in that not only is it one of our major cities but it has a very large motorway running through its middle. There are particular issues in Glasgow with early deaths and so on. Does the panel think that we need specific, place-based interventions or wider system change on air pollution and other determinants of poor health?

The Convener: I will bring in Professor Burns first.

Professor Burns: There is no doubt that it can help to measure things such as air pollution, not just outside but in homes, schools and so on—and doing that has become much more important with the advent of Covid, which has made us interested in ventilation and so on.

However, I come back to the point that the major drivers of inequality and life expectancy in Scotland are not things such as heart attacks and cancers, but the wide differentials in deaths

among young, working-age people due to things such as drugs, alcohol, suicide, violence and accidents. Yes, we can and should look at individual issues, and air pollution is an important aspect, but if we are to achieve success, we are going to have to support young people who get themselves into difficulties with drugs, alcohol and so on, because they are the ones who will die young as a result of being in those difficulties.

A study from the University of Glasgow some years ago showed that heart attack deaths were a relatively small contributor to health inequalities. The difference in death rates from drugs, alcohol, suicide and violence begins to shoot up in the teenage years. I am really keen that the Parliament should focus on the creation of wellbeing in families and on support for families in the early years. All the other things are important, but if we do not do the early-life stuff, the other things will have a relatively minor impact.

Professor Marmot: I will make three points. First, I talk to a lot of different disease-specific groups, and I was asked to talk to dentists about oral health. I showed them two graphs featuring the social gradient by deprivation. By classifying people by where they live and classifying where they live by deprivation, divided into deciles—10 per cent—you can see a gradient. I did not put labels on the Y axis—I did not say which diseases I was looking at. The gradients were identical. When I put the labels on, one was Covid-19 mortality, and the other was decayed, missing and filled teeth in children. The gradients were identical.

When I gave a talk to some heart disease people, I got a third graph, which I did not label either. It was for childhood obesity. The gradient was identical. We could focus on cardiovascular disease, oral health or Covid-19. Covid-19 is caused by a virus; dental caries are caused by diet and poor oral hygiene; and childhood obesity is caused by—well, your guess is as good as mine—but they all show identical social gradients. I could show you graphs of air pollution in schools in London, which have an identical gradient. The poorer the area of London, the higher the degree of air pollution in schools.

I am happy for the heart disease people to focus on childhood obesity, for the oral health people to focus on reducing dental caries and for the infectious disease people to focus on Covid-19, but we have to deal with the inequalities that underlie each of those specific conditions. That is the first thing to say.

It is not an either/or question. I recently reviewed Jeremy Farrar's book, "Spike", on Covid-19, Jeremy Farrar being the director of the Wellcome Trust and a member of the scientific advisory group for emergencies—SAGE. I think he mentioned inequalities once in the book, but I did not pan it because of that. It was a brilliant book; I enjoyed reading it, I learned a lot and I gave it a very positive review. However, I did comment. My approach is to deal with the inequalities; his approach is to deal with control of the virus. It is not either/or; it is both—we need both those approaches.

Turning to my second point, should we focus on particularly high-risk areas, or do we need something more general? In my 2010 English review, I coined the rather awkward phrase "proportionate universalism". It was the classic British compromise. I was trying to deal with the classic Anglo-Saxon approach to social policy, which is to target the worst off, and the more Nordic approach, which is to have universalist policies. When Harry Burns was chief medical officer for Scotland, he said that he was all for Nordic universalist approaches. I was trying to bring the two together. When we accept that there is a gradient, if we focus only on the worst off, we miss most of the inequalities, which are not confined to the very worst off. We need effort that is proportionate to need—hence, proportionate universalism. I think that that is absolutely right. We need to improve air quality for everybody, to take that example, and we need to work harder in the most polluted areas.

The third thing that I wish to say, particularly in relation to air pollution, illustrates the more general point that we need to make common cause between dealing with health inequalities and dealing with the climate crisis. In 2021, in Glasgow of all places, it is the right time and place to be thinking about that. The big advantage in that context is that, if we achieve net zero greenhouse gas emissions, we will reduce air pollution and improve health as a result. It is crucial that we make common cause with dealing with the climate crisis and reducing health inequalities.

09:30

The Convener: I am assuming that, if witnesses put an R in the chat box, they want to come in. The clerks are feeding that information back to me. Does Professor Smith want to add anything?

Professor Smith: I will be very quick. I agree with a lot of what has been said. A systemic approach to air pollution must be taken, because many of the things that impact on that are system-wide issues, such as transport, infrastructure and the location of factories. I like Professor Marmot's really useful concept of proportionate universalism.

If we focus only on places, which sometimes happens in our efforts to address health inequalities, we lose that wider national outlook

and end up zoning down on policy levers that exist at a local level, which are often insufficient. Instead of focusing on the wider issue of health inequalities at a national level, we end up focusing on small-level improvements in particular areas. It is important to make the small-level improvements that local areas offer, but it is really important that we combine that with systemic cross-cutting planning at national level. As Professor Marmot said, when we make decisions that impact on climate change, we should think about how those decisions impact on health and link together. I encourage the committee to focus on what the Scottish Government is doing to make links across different policy areas.

The Convener: Sue Webber has questions on that issue.

Sue Webber (Lothian) (Con): There is a lot of synergy in what we have heard about tackling health inequalities. I am interested in what Professor Burns said about current policies focusing on a top-down approach and the need to focus on a bottom-up approach if we are to help young people when they are in difficulties and prevent their early death from suicide, violence, drugs or alcohol. We live in a world of finite resources, and we want to focus on a bottom-up approach, so what do we do about the top-down approach, because we cannot be everywhere? Right now, our resources are going towards tackling waiting lists, and hip and knee replacements are for the older generation, but you said that we need to focus on supporting the young. How do we square that with the public? How best should we do that?

Professor Burns: Your sound broke up a wee bit, but I think that you are asking how we square what politicians in Parliament can do with the bottom-up approach. The most important thing is to give people on the front line the permission to begin to do stuff.

I will give an example. I spoke to a group of district nurses in a significantly deprived part of Scotland who told me that, when they get together in the office for cups of tea, they share stories about families and so on. They knew about 30 families who were really struggling, and they wondered how often they went to the accident and emergency department of the local hospital. They got the names together, asked the local hospital and found that members of those families were going to the local A and E department once or twice a week. One of the district nurses happened to be talking to the local community police officer, who said, "I know who those people are." He went away to find out how often members of those families were dialling 999 and, again, it was a very high number.

I hear those kinds of stories all over the place, and what I take from them is that we need to bring together the front-line staff in the different parts of the system and ask them, "Who is struggling and how do we reach out to them?" Because it is difficult to get the data, I have never done so, but if we asked the local education department about the children in those families, I bet that we would find that the children attended school only 50 per cent of the time.

Therefore, it is a whole-system problem, and the most important thing is for Parliament to give permission to the front line to begin to reach out to those individuals and ask them, "What do you need? How can we help you? How can we support you to improve control over your lives?" From a whole range of studies that have been done, we know that control is the most important thing. Hopelessness and helplessness cause such families to struggle, so if we give them hope and a feeling that they can be in control of their lives, we will find that a lot of those issues turn around. We need to create an environment that allows individuals to be helped by front-line staff and that allows front-line staff to come up with solutions.

I have just finished a year as president of the British Medical Association. I do not get involved in the politics of the BMA, but it supports me in doing a project. As part of that project, I asked all the general practitioners in Britain to send in stories about how they helped struggling families. We are pulling those stories together and we will have a conference about the project next month. We need to pull together and share those stories of how we reach out to individuals and change their lives, so that we can begin to build a programme of support for families who are struggling.

Sue Webber: I have a quick follow-up question. Professor Burns, you spoke about how difficult it is to get the data. In the example you gave, members of front-line staff showed a lot of initiative and did some digging around. In terms of data sharing, how important is it for us to have systems that talk to one another?

Professor Burns: That is very important. I have struggled to get data. I have a research assistant who has been trying for a long time to pull together data to allow us to begin to identify people who need help, but I think that I am making progress with the Scottish Government on that. Under general data protection regulations, in effect, all that data rests with the Scottish Government, and we need to pull it together. Let us say that the data tells us that, in an area of Scotland, 500 people are in difficulty, so we begin to support them in different ways. If we follow that up a year later and find that that 500 has fallen to 100, we will know that we are making progress.

There are examples. A few years ago, the city of Stoke-on-Trent calculated that the public sector was spending about £100,000 a year on individuals who were struggling. Once the city implemented the provision of bottom-up support, the figure fell to about £400 or £500 a year. Those are very soft figures, but they show that the public sector can do things differently and save a lot of time and effort in the process.

Professor Marmot: The question about whether to have a top-down or a bottom-up approach is such an important question. In my research, I put a lot of emphasis on how much control individuals have at work, because being in situations without control increases the risk of physical and mental illness. Indeed, when I chaired the World Health Organization commission on social determinants of health, we privileged empowerment, which we thought of as acting not just at an individual level but at community and, indeed, national level.

In its recent—and much maligned, including by me—report, the commission on race and ethnic disparities said, "No, no, no—there's no structural racism in Britain. We think that individuals and communities should be empowered to take control of their own lives." That really gave me pause and made me think, "Have I got this wrong?" When I saw that a group that had said that there was no racism and that there were no structural causes of inequality had also said that it was up to individuals and communities to act for themselves, it made me think that everything that I had been saying for decades was completely wrong.

I do not think that allowing people to take control of their lives means that the state should have no role. I have written about poor parts of Glasgow based on case histories that were given to me by John Carnochan, a detective superintendent in charge of homicide. He described a typical individual growing up in Calton in Glasgow. This boy had a single mother; the family moved home every 18 months; and the mother had a succession of partners, each of whom abused this young fellow. By the time he went to school, he had already been labelled as having a behavioural problem. As soon as he was old enough, he was involved in gangs and was then labelled as a juvenile delinquent. He never had a proper job; he drank, smoked and did drugs; and he was thrown out by girlfriends because of his violent behaviour.

Are we going to come along and say to such a person, "We're going to let you take control of your life. Pull your socks up and look after yourself. Stop drinking, eat properly, get a job and stop abusing your girlfriend"? That is a parody—a grotesque caricature. Instead, we need to create the conditions for people to take control of their lives. If that young person had had a stable background and a decent education and then chose to do whatever he did, that would be up to him. However, if we do not create the conditions that allow people to take control of their lives, we are not doing our job properly.

My response, therefore, to the question of whether we need top-down or community involvement is that we need both. Ultimately, people should be able to take control of their lives, but we need to address the social determinants of health and health equity that give them the capabilities to do so.

The Convener: You wanted to come back in, Professor Burns.

Professor Burns: I want to go back to what Professor Marmot was saying with regard to some people making good decisions while others make bad ones and some people being in control while others are not. I point to the strong body of scientific evidence that shows that children who experience chaotic early lives are less well able to make such decisions. Studies that were done in America first of all show that, in children who had experienced adversity in early life, the centres of the brain that control emotions, decision making and learning developed abnormally. We did some studies in Glasgow that showed exactly the same thing. People at the lower end of the social scale had structural abnormalities in the brain. We measured function, as well. Those individuals were more emotionally arousable. They were more anxious, aggressive and fearful, less well able to make decisions when faced with difficult choices, and less well able to learn at school. That is what happens when people have a chaotic and difficult early life.

09:45

Regrettably, Bruce McEwen, who was the neuroscientist in New York who showed that, died last year. However, before he died, he told me that he had done a study that showed that those changes could be reversed in later life. An important part of the process of repairing and restoring from those problems is mentoring—the support of a trusted other person to help those individuals to begin to feel in control of their lives.

The system is very complex. It is right that we need top-down support to allow people on the front line to engage and help those individuals in an appropriate way. We also very much need the ability to pull together the data that demonstrates that we are making change happen.

Professor Smith: I am going to turn my video off. That might help.

I go back to the original point about how we decide what to focus on if we have limited

resources. I completely agree with what Sir Harry Burns said about having to think about systems and how the different bits of the systems interact. We can do that at the local level, as Sir Harry Burns described, and we can also do it at the national level, in respect of how we make national policy decisions. I am currently involved in a project that is trying to support the Scottish Government to do that—there will be others. The project that I am involved in is funded by the UK Prevention Research Partnership and is called SIPHER—systems science in public health and health economic research. It is trying to implement decision-support tools based on systems modelling rather than the more silo-based modelling that we have tended to have. It is looking at what happens if one thing is done—one policy decision is made—in the system and how that impacts on the other areas of the system at the national level.

We need that national level systems thinking as well as the local level systems thinking and, for that kind of modelling and systems thinking to work, we need good data, so I also agree with what Sir Harry said about that. The Covid pandemic has highlighted data around ethnicity, which is a key area that Scotland is not doing particularly well in. That is really problematic in Scotland. It would be good to ensure that more effort is put into ensuring that we have the right data. If we are not even capturing the data that we need, we cannot feed that into that kind of evidence-informed decision making and modelling.

It is, of course, really important to bring the public with you in a democracy but, for me, that does not mean doing things only at a grass-roots level. We also need to think about what mechanisms we have in Scotland for bringing the public into conversations about macro level policy decisions. How are we having those public conversations? Where are they taking place?

I have done research over many years that has looked at how policy makers and researchers have tried to tackle the issue of health inequalities. In the course of that research, many people have told me that members of the public do not support the kinds of evidence-informed policy proposals that researchers have put forward. However, when I explored that idea via a national survey in citizens juries, that did not appear to be the case. In fact, members of the public seemed to understand the social determinants of health very well—particularly, as we might expect, if they had experienced deprivation—and they were also very supportive of policy decisions that were trying to address social determinants of health, such as housing. They gave clear and persuasive accounts of how changing something such as housing has a knock-on impact on many different aspects of people's health and wellbeing. Therefore, it is really important to think about how we have those public conversations, and we also need research to better understand what the public actually think about issues such as health inequalities and potential policy interventions.

The Convener: We will now move on to questions from Emma Harper.

Emma Harper (South Scotland) (SNP): Thanks, convener, and good morning to our panel of experts.

The Scottish Government has published its public health priorities, with a number of items that need to be addressed. Among the priorities are:

> "A Scotland where we flourish in our early years ... A Scotland where we have good mental wellbeing ... A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs".

Six priorities are listed. This is the first time that Scotland has had a simple, overarching public health strategy, and it is the first time that the national public health priorities have been aimed at wider determinants of health.

I am now co-convener of the cross-party groups on health inequalities, on improving Scotland's health and on diabetes. I am trying to bring them all together so that we can have everybody round the table having the same conversation, instead of having different conversations in silos.

I am interested to hear whether the expert panellists agree with the Scottish Government's public health priorities. Do you think that something needs to be added?

Professor Marmot: From what you have just said, that is a pretty good list. In my English review, I had six domains of recommendations to reduce health inequalities. Interestingly, a Swedish commission picked up my six, which I will tell you, and it added a seventh, which I will also tell you. I think that they apply well to Scotland.

The first domain was early child development: give every child the best start in life, with equity from the start. That is exactly what Harry Burns has been talking about and what you have just said.

The second domain was education and lifelong learning.

The third was employment and working conditions. It is important that the transition from school to work and reducing the proportion of young people not in employment, education or training are in that.

The fourth recommendation was that everyone should have at least the minimum income necessary for a healthy life. That is a hot issue this very week in England, with £1,000 a year about to be taken off universal credit. It took a young

footballer to get the Government to do a U-turn on free school meals for people who could not afford to feed their children. It somehow took a young footballer to shame the Government into saying that it was really not very good if poor kids went to bed hungry.

The fifth, which relates to the earlier discussion about pollution, was on healthy and sustainable places in which to live and work. That includes housing—[*Inaudible*.]—environments and transport, and that very much relates to the climate issue.

The sixth was about taking a social determinants approach to prevention. Harry Burns talked about drugs and alcohol; we could add smoking, diet and exercise. That is not simply about telling people to eat well or to behave properly; it is about dealing with the social conditions relating to behaviours.

The seventh domain, which the Swedes added in their commission, was people having control over their lives. That, of course, underpins the others.

Those would be my priorities. If you ask me what I would recommend for Scotland, I would recommend those same priorities.

Professor Smith: I am very supportive of Scotland's public health priorities. They are a great list of priority areas. Tackling inequalities in wealth and poverty is not as clearly highlighted in the list as it could and should be for Scotland but, beyond that, it is a really good set of goals that Scotland is aiming for.

The issue is how we achieve those goals—how we create the policy decisions that will achieve those policy priorities and goals and make them realistic. That is where we need the systems thinking. It is a wide-ranging list that cuts across a huge range of policy areas, so you need policy tools that will help you to think about where you will get the win-wins and the best returns on your investment in that system. That is a key point.

The other issue is how policy making in the Scottish Government interacts with the wider political system. It is great to see the Scottish Government trying to join up its policy making on public health—I know that the public health reforms have all been centred on that. However, when policy making interacts with that wider political system, the lobbying and advocacy that goes on, with different organisations, for very good reasons, trying to influence policy, can pull things back to silo-based policy making. We need to think about how Scotland can maintain that focus on joining things up and not get pulled into focusing on one specific issue because there is lots of advocacy and lobbying and lots of media attention on that issue.

As Sir Harry Burns said, it can be politically very attractive to feel that you are fixing one very clear thing and that you can see what you are doing on that issue. We need to get on board with the public health reform agenda but maintain that cross-cutting approach and really go with that systems thinking and thinking about where you can get your best buys.

Professor Burns: [*Inaudible*.]—both Michael Marmot and Kat Smith on what they have been saying. We have to get in behind it, but the question is: how do we do that? How do we deliver it? In fact, Scotland has a good track record on that. When we did the patient safety collaborative about 10 years ago now, we reduced surgical mortality and standardised mortality rates in hospitals significantly. Internationally, the way that we did that was held up as world leading. We did it by asking front-line staff to come up with ideas.

I can tell you a story about the early years collaborative. It was decided that one of the things that we needed to do was to ensure that 90 per cent of all children reached all their developmental milestones by the 30-month health visitor assessment. When we started doing that, we discovered, to our horror, that only 60 per cent of Scottish children actually got a 30-month health visitor assessment.

All sorts of heads were being scratched, but one health visitor in one clinic in one health board authority wondered whether parents were not turning up because the appointments were sent out in brown envelopes—brown envelopes are not very popular in houses in deprived areas. She started to text the times of the appointments to families and, before we knew it, 90 per cent of all children were being brought for their assessment. She told all the other nurses in that clinic, who told all the other nurses in that health board and, eventually, across Scotland, 90 per cent of all children were being brought to their assessments. That shows you how one front-line staff member can have a clever idea and a clever insight and that, if we spread the learning, we get significant change and improvement.

Before we started the early years collaborative, Scotland had the highest mortality rate of the four UK countries; now we have the lowest infant mortality rate of the four UK countries. Big change can take place. Sitting in Holyrood and in academic departments and so on, we can say, "This is how we might do it," but actually doing it requires the involvement of front-line staff to help to shape and deliver it. Yes, let us go full pelt with that list of priorities, but let us create a collaborative approach to make it happen.

Emma Harper: I am thinking about low-hanging fruit. Healthcare providers are starting to get more education about adverse childhood experiences.

Police officers in South Ayrshire are now going through training to recognise ACEs, which is really important. When I started my vaccination programme training, there was nothing in the e-learning modules about tackling stigma related to alcohol and drugs for healthcare professionals who work outside alcohol and drug services. If we are thinking about low-hanging fruit and on-the-ground delivery of education, do you think that we need to consider ensuring that healthcare professionals know about adverse childhood experiences as well as things such as the stigma that is related to alcohol and drugs?

10:00

Professor Burns: You are absolutely right. We need to be aware of those issues. I have been working with Police Scotland and councils in Ayrshire and elsewhere to get them to realise that. Some people are taking that point on board very well.

Systematic training around adverse childhood experiences is important. A lot of our learning on adverse childhood experiences comes from a big study that was carried out in California many years ago that showed clearly the link between the number of adverse childhood experiences and the extent of poor health and wellbeing outcomes.

The interesting thing about the adverse childhood experiences clinic is that it started off life as a weight reduction clinic. The clinicians wanted to reduce people's weight, but they found that they could not do so with lots of folk. By chance, one of them discovered that the patients whom he was dealing with had suffered abuse and neglect as children, so it was changed to an adverse childhood experiences clinic. That shows you just how complex a problem such as obesity is. When I hear ministers say that they want to ban the advertising of high-calorie foods on television, I think, "Aye, that'll be right; you'll get a good result out of that." The issue is much more complex than that—that is the basic problem.

You are right. Awareness of adverse childhood experiences is important, as is collecting the data, identifying the people who need help and support, and not stigmatising them. They are as they are because of the situations that they were in. Helping them to take more control of their lives is the way ahead.

The Convener: A couple of members want to ask questions about policy priorities. However, before that, I believe that Professor Marmot would like to comment on the issue that we are currently discussing.

Professor Marmot: I have been to three meetings in Edinburgh about early childhood. The third one was specifically about adverse childhood experiences, and I was very impressed by the level of focus on that issue in Scotland. During the coffee break, a group of public health students from the University of Edinburgh were buzzing around me and filling my ear with the view that it is all very well for practitioners to be concerned with adverse childhood experiences but that it is also important to consider the social and economic drivers of those experiences. That is exactly what Katherine Smith said earlier. We cannot just get practitioners to focus on adverse childhood experiences and ignore the social and economic inequality that gives rise to those experiences. We know that adverse childhood experiences follow the social gradient. If you look at nine specific adverse childhood experiences, you will see that they all increase in frequency with deprivation—the greater the deprivation, the greater the frequency of ACEs.

It is great that practitioners are aware of the issue and are focusing on it, but the issue in general absolutely emphasises Katherine Smith's point about the importance of putting ACEs in the context of addressing social and economic inequalities.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): You have already answered a lot of my questions. Adverse childhood experiences are often on the edges of lots of other things that we talk about. I feel that the film "Resilience" should be shown everywhere or, at least, to everyone in the public sector so that people really understand how toxic stress changes the brain and how it can impact on people in later life as well as affect their health and wellbeing all the way through.

Is there a case for having a specific focus on ACEs? Should we be working with young people on the issue, talking to them about it in schools and asking them to consider whether they have any ACEs in their own backgrounds? I know that a lot of people who work in public health and social work have suffered quite a lot of ACEs in their lives themselves, so despite all the negative impacts, there are also some positives to consider.

This is not about just writing down a list of things that might have happened to a person and then saying to them, "You're going to have problems in your life because of these things." Instead, we need to sit down and look at and understand the issues. This is about being in control and having a sense of wellbeing as well as about understanding and appreciation.

The Convener: Were you directing those comments to anyone in particular or should I just go round everyone?

Stephanie Callaghan: It is fine to ask for general comments.

The Convener: I will ask Professor Marmot to respond first and then bring in our other panellists.

Professor Marmot: Forgive me for going far afield, but when I visited Australia I was interested to see that, with regard to the health of indigenous Australians, the default position of the care services was not whether but when to take a child into care because of adverse childhood experiences. The default was that Aboriginal parents were incompetent; drug and alcohol abuse and domestic violence were involved; and the children needed to be taken into care.

However, pretty well almost everybody to whom one speaks agrees that taking an Aboriginal child into care has disastrous consequences, and it costs about $100,000 a year. My question was: for $100,000 a year, could people not work with the families to do something about the problems of drugs, alcohol and domestic violence? In Victoria, there is a group of healthcare organisations that are controlled in the community by indigenous Australians. In one rural district, they told me, "We're doing this. We've taken formal responsibility and we use the money to work with families on the problems of drugs, alcohol and domestic violence." Their default position is to keep the families together and deal with the problems.

I never make the economic case for doing the right thing—I think that we should do the right thing because it is the right thing to do—but these people are making the economic case, too, that dealing with the source of these problems in adverse childhood experiences is quite cost efficient. Given the problems that come down the line if you do not deal with it, it is worth spending the money up front.

As I said in response to the question about whether there should be top-down or community control, we need both. We need to deal with the structural drivers, but we must also have community and professional engagement in order to deal with the problems of ACEs where they occur in families and communities.

Professor Burns: I am reluctant to label families and say that the problem is all due to ACEs. Part of the problem is that we have tended to focus on and tried to do something about a particular thing, and there is a great risk in doing so.

There are families in which the parents are very loving and keen to do the best for their children but just do not have any money or resource to fall back on. The issue is about providing support for families, but not because they are so-called bad families. Telling people who are struggling that they are bad and that their children might have to be taken away will just make them feel even more hopeless. That is a classic example of when we need people on the front line to go in. My conversations with Police Scotland officers have shown them to be really understanding about that. They see the consequences of chaotic families. The policemen whom I have spoken to say, "We don't want to disrupt those families; we want to help them." We need Parliament to send a positive message that building trusting relationships with struggling families works.

A couple of years ago, I was at the national rural health conference in Australia, and exactly what Michael Marmot talked about was happening. There was a really interesting presentation from two guys who spoke to homeless folk. One of the things that homeless people were anxious about was the fact that their clothes were dirty, so those guys got a van, put a washing machine and a tumble dryer in it, drove around the city to places where they knew homeless folk congregated and washed their clothes for them. Solutions emerge in unexpected ways. That system has now spread to many Australian cities.

If we ask people what they need and help them to achieve that, they begin to take control of their lives. Although I talk a lot about ACEs, I do not want people to be labelled in such a way or there to be a national ACEs programme; I want a "let's help people who are struggling" programme.

Professor Smith: I very much agree on the importance of focusing on early years, on which the research literature is very strong and goes back decades to the Black report and beyond. It is clear that, if we want to tackle health inequalities and inequalities generally at a societal level, we need to think about early years.

For many of the reasons that Sir Harry Burns has given, I share his concerns about a focus on ACEs and explicitly labelling them as such. First, lots of different issues are merged under that label, and they sometimes need to be unpicked a bit. Secondly, it becomes a label in itself, which is exactly what Sir Harry Burns warned about, and that label could be quite stigmatising. Thirdly, a recent review of the literature on ACEs by David Walsh from the Glasgow Centre for Population Health and his colleagues found that only a tiny proportion of the literature explores the socioeconomic context of ACEs. If we do not make those links, we miss a huge amount of the picture. If we focus on ACEs, it is important that there is a wider conversation and that the label does not become a stigmatising tool that makes conversations difficult and people unwilling to engage.

Paul O'Kane (West Scotland) (Lab): My questions are on Covid-19 and its wide-ranging impacts. Every day, we see the direct impacts of the disease in terms of the number of

hospitalisations and deaths, but I am interested in the longer-term indirect effects on health and in the impact that long Covid might have, particularly on people who already suffer from poor health or live in areas of deprivation.

If we take long Covid first, I am keen to understand its impact. We obviously do not have a lot of data and information on it yet. That is emerging, and there is still a long way to go in terms of interventions, but I am looking to get a sense from the panel of the impact that long Covid will have and what interventions it might require.

10:15

Professor Smith: I could say more about the impact that Covid has had on how we think about health inequalities and public health than about long Covid specifically, precisely because, as you said in your question, the data on long Covid and our understanding of it are limited at the moment. There appears to be a gender and an age group dimension to it, but evidence in that area is rapidly evolving. It is probably too soon to make a call about what the impact of long Covid will be, but it seems that it will be unequal, as we would expect and as the more general impact of Covid has been.

Generally, the way that the Covid pandemic has played out is as what my colleague Clare Bambra calls a syndemic, in that it has interacted with existing health and societal inequalities. Those inequalities have worsened the impact of Covid and made it more unequal, and the impact of Covid is making the inequalities worse. It impacts directly in terms of who has been most at risk of getting sick in the first place and who is most at risk of serious complications and illness if they get sick. The wider implications of its impact on people's ability to work, care for their families and so on, have also been unequal, which is unfortunately exactly what people working on health inequalities would have predicted at the start.

In the context of health inequalities, Covid has drawn attention to an issue that has been on the agenda for a long time but has not had enough of a policy focus to reduce the inequalities in the way that we would like to. Many of the factors that explain why the impact of Covid-19 was so unequal are precisely the same social determinant factors that we have talked about for so long in the context of health inequalities. Certain people are more vulnerable because they already have a higher burden of other illnesses, their immune systems are not as effective, and they are more exposed to it. They are more likely to have had to go to work and to be living in cramped housing conditions, and they have less access to nice outdoor space, so there is increased transmission.

All those reasons explain the unequal impact of the pandemic and we would expect to see that in the impact of long Covid. What can we do about that now? I would be wary of trying to be too ameliorative. It really behoves us to think about the more upstream social determinants approaches that have been on the agenda for so long but that we have not quite managed to nail in Scotland in the way that I think we have the potential to.

Professor Burns: [*Inaudible*.]—locus of control if you feel pushed around by circumstances outside you and are not able to overcome them. If you feel rubbish all the time, if you are tired, have chronic headaches and so on, that just worsens your sense of control. For people at the lower end of the social scale who have a poor sense of control, it will just make life worse in a way that is very difficult to detect. There is no test to show that people have become more depressed, isolated and so on, because the combination of inequality, poverty and Covid has made a difference.

One of the most striking things has been the differential death rates in affluent and deprived individuals. I will speculate on one of the reasons for that and I would love to hear what Professor Marmot thinks about it. There will be a reason in as much as people at the lower end of the social scale will already have a number of conditions that will make recovery difficult for them.

Many years ago, Professor Marmot described the fact that people at the lower end of the social scale have higher stress hormone levels than people at the higher end. One of the things that has been speculated in relation to Covid concerns the idea of a cytokine storm—a rush of stress responses that damage the body. That might well explain some of the difference.

Covid has worsened inequality and will continue to cause problems for people at the lower end of the social scale if they have continuing effects of having had the virus.

Professor Marmot: I agree completely with what Katherine Smith and Harry Burns have said so eloquently. Covid and the response to it, in the form of the lockdown, have amplified the underlying inequalities in society. Because we have controlled the pandemic so poorly, inequality has increased.

Let us take a step back and think about excess mortality in the first phase of the pandemic, in the first half of 2020—that is, the difference between the expected level of mortality, based on the previous five years, and the level of mortality that actually occurred. We know that the excess mortality was higher in England than in Scotland and that it was higher in Scotland than in Wales

and Northern Ireland. We also know that the excess mortality in the UK as a whole was higher than it was in any other rich country. We look at the US and say that its handling of the pandemic in 2020 was a disaster, but we were worse: we had higher excess mortality than it did. The excess mortality in the US is now higher than it is in the UK, but we are right up there.

When I looked at the Johns Hopkins University figures yesterday, I saw that we are at about 45 new cases per 100,000 people daily, and the US is at about the same. However, our rate is about four times higher than the rates in Germany, France and Italy. We have managed the pandemic appallingly badly.

I saw recently that, from 2010 to 2019, the UK showed the slowest improvement in life expectancy of any rich country apart from the United States and Iceland, although it was only the US that really did worse than us. If you look at the excess mortality during the pandemic and the improvement in healthy life expectancy in the decade before the pandemic, you can see that the worse the improvement in health before the pandemic, the higher the excess mortality during the pandemic.

I have asked myself what the link is. Why do countries that have a poor health record before the pandemic have a poor record of managing the pandemic? I think that the link potentially works at four levels. The first is the quality of governance and political culture. We really managed the pandemic badly. You know, when freedom day was declared in July, we had 45,000 new cases that day. In Australia, when they had 1,000 cases, they had a complete lockdown, but 45,000 cases was a fine level for us to declare freedom.

The second level is the increasing social and economic inequalities—the kinds of things that Katherine Smith was referring to. The third is the disinvestment in public services during the previous decade. The fourth was that we were not very healthy coming into the pandemic, and that increases risk.

Standing back, it is plain to see that the pandemic increased inequalities, and part of the reason for that is that we managed it so badly. For example, we asked people to isolate but did not give them the economic resources that made it possible for them to do so. A study from Liverpool showed that one reason why poorer people were not coming forward for Covid testing was that they were scared that, if they tested positive, they would have to stop work, and then they would starve. We did not make the proper economic arrangements to help us control the pandemic.

That is quite apart from the point of Harry Burns's speculation—which I agree with—that being lower in the social hierarchy puts you at higher risk of a whole range of disorders because of stress responses.

David Torrance (Kirkcaldy) (SNP): Good morning. With the pandemic causing huge backlogs for the national health service, as well as pressure on it from politicians and the media especially, do you think that primary prevention will be neglected?

Professor Burns: I am sorry, I am not quite clear what you are asking. Is it about primary prevention of other conditions?

David Torrance: Yes.

Professor Burns: I have no insight into that. If you are talking about the increased workload of the health service, it is clear that things such as follow-ups to screening tests have, in some places, been put on hold, and we are seeing the consequences of that.

I have been thinking that there should be an audit. We should look very closely at what tests and interventions have been delayed, because there is a chance that things will get worse as we move into winter. I get the sense that the NHS is trying very hard to recover but, if things get worse over the winter—as we might expect them to do—we might be back to square 1.

Therefore, we need to try to understand where and why the delays are happening now. This week there has been a lot of discussion about a shortage of ambulance crews. Are there specific bottlenecks in the process of moving people through the system that we should be tackling? We are only going to know that if we collect data. I am not sure whether that is being audited. If not, it should be, and plans should be laid to cope with a worsening situation as we move into winter. I hope that that does not happen. I hope that the third-immunisation approach to the over-55s will help with that, but things always gets worse with flu in winter. We need to start preparing for it now.

The Convener: I am very conscious of time. I am going to bring in Gillian Mackay and then Sandesh Gulhane, and then we will have to wrap up.

Gillian Mackay: We have talked about people's incomes, particularly during the pandemic. Furlough is due to come to an end, universal credit is being cut and incomes generally are declining for those who are least able to afford it during the pandemic. Would the panel agree that a universal basic income approach could help to tackle some of the economic inequalities that lead to poor health?

The Convener: I would have liked to have brought in Professor Marmot at this point because he brought up that point but he has had to leave. I

ask Professor Burns to answer and then Professor Smith.

10:30

Professor Burns: I am a fan of universal basic income. The evidence that we gather from studies in the US and Canada shows that it works. It significantly improves health and wellbeing.

I was told that, on the basis of its studies, America was prepared to make universal basic income a civil right but it was suggested that it led to an increase in the divorce rate at the time that it was being tried. Folk said that that is what happens when we make women financially independent of their husbands—they divorce them. In fact, that was a complete fabrication. The divorce rate did not go up but infant mortality fell and engagement with schools increased, for example. There are a number of very significant benefits from UBI and I am a supporter. I do not understand why the trials that were proposed never came to anything.

Professor Smith: I agree with Harry Burns. All I would add is that there are many different designs for universal basic income. We can set it at different rates, which has big implications for how it functions in relation to inequalities. However, I agree that it is a shame that the proposed approach for trialling it in Scotland does not seem to be progressing. It would be good to see that being reconsidered.

The Convener: We are coming up against the deadline for this panel of witnesses because we have a second panel, but I will bring in Dr Gulhane.

Sandesh Gulhane (Glasgow) (Con): Countries with the best-working primary care seem to have better outcomes on health inequality. With GPs being completely overwhelmed, will health inequalities increase and general health decline?

Professor Smith: Unfortunately, health inequalities will get worse in the context of the pandemic because of how the pandemic and health and societal inequalities have interacted.

GPs being overwhelmed is a real concern but, if we think about the longer-term impact of the pandemic, there are opportunities for how people think about their health and wellbeing and how they interact with the health service. Public health is much more in public and media conversations than it was previously, which provides an opportunity to facilitate better conversations and interactions. We could try to build on that wider public and media awareness of public health and the importance of interacting with health services. It would be good for Scotland to do that.

Professor Burns: [*Inaudible*.]—and giving them less time to unburden themselves. I have said several times that the most important thing for someone who is struggling is the sense that they have someone who listens to them, whom they trust and whose time they value. If GPs are not able to give people time because they are overwhelmed, that will cause individual problems. There is no doubt about that.

The best GPs that I know and speak to regularly are still trying hard to give a listening ear to the people who they know are struggling. It comes down to individuals who are going out of their way to do the right thing for their patients. In Scotland, we have a high quality of primary care available to the population in general.

The Convener: Sadly, we will have to allow the witnesses to go. There is so much in what they have said. I thank Professor Burns, Professor Marmot and Professor Smith for their time.

We will take a very short break—I emphasise "very short"—before our next panel of witnesses.

10:34

Meeting suspended.

10:40

On resuming—

NHS Stakeholder Session

The Convener: Item 4 is a round table with stakeholders to discuss key themes and issues facing the NHS in Scotland. It is intended to inform the committee's discussions on its future work programme. I welcome Dr Sue Robertson, who is deputy chair of the British Medical Association's Scottish council; Donald Morrison, who is a general dental practitioner with the British Dental Association; Ross Barrow, who is vice-convener of the Allied Health Professions Federation Scotland; Graeme Henderson, who is executive director of delivery and strategic development for the Scottish Association for Mental Health; Kate Seymour, who is head of advocacy for MacMillan Cancer Support; and Colin Poolman, who is director of the Royal College of Nursing in Scotland.

With six witnesses, we have a little bit of housekeeping to go through. I have asked committee members to direct their questions to specific individuals. If any of the witnesses wish to come in and add anything, please use the chat function; if you put an R in the chat box, the clerks will relay that back to me. I will try to bring you in as much as possible, rather than have everyone answer the same question—we do not have the time for that, sadly.

First, however, I want to open things up by asking a question of everybody—this will be the one exception to the housekeeping rule that I just set out. What do you want the Scottish Government to prioritise in the health and social care portfolio—not only the portfolio of the Cabinet Secretary for Health and Social Care, but the relevant ministerial portfolios—over the next five years?

Dr Sue Robertson (British Medical Association): Good morning, everybody, and thank you for having us.

What do we do for the next five years? We need to address the vacancy rates in the NHS in Scotland, and the fact that the workforce is exhausted. The vacancy rates are high, and demand has gone through the roof. The public messaging around the Scottish Government's NHS recovery plan states that we can increase capacity to 110 per cent, but there are no realistic plans to increase the workforce in the short term. We think that that creates a perfect storm.

We want to engage to try to find solutions. I was struck by what Professor Burns said in the previous evidence session: that we can create wellbeing by creating an environment where people feel safe and supported, and that "hopelessness and helplessness" create ill health. There are staff in the NHS in Scotland who feel hopeless and helpless; they are keen to engage, but nobody is engaging with them. There is abundant evidence that workforce stress in healthcare organisations affects the quality of care for patients as well as staff health. Prioritising staff health and wellbeing will allow the NHS to retain the staff that it has and make it a better place in which to work.

The Convener: I offer my apologies to Dr Vipin Zamvar—I stupidly did not read to the end of my list of witnesses, and I did not include you in that list. I will come to you now for your asks of the Scottish Government in its prioritisation.

10:45

Dr Vipin Zamvar (British Association of Physicians of Indian Origin): Hello—can you hear me, convener?

The Convener: Yes, we can hear you perfectly.

Dr Zamvar: Thank you for inviting me to the meeting. I am here as the chair of the British Association of Physicians of Indian Origin. I have seen the five-year recovery plan, and I would like to mention a few things. There are issues that affect black, Asian and minority ethnic doctors in particular, and I am here to raise the issues that affect that group of medical professionals. About a third—

The Convener: Your picture appears to have frozen, Dr Zamvar.

We hope to come back to Dr Zamvar once his connection is re-established. I will bring in Donald Morrison.

Donald Morrison (British Dental Association): Thank you for letting me speak today. For context, I have been a general dental practitioner—a high-street dentist—for nearly 25 years. I worked in the NHS in England for 10 years, and for the past 14 years, I have worked in Scotland. I currently run and work in a practice in Ayrshire; it is a mixed dental practice, and we are responsible for nearly 6,000 registered NHS patients. Today, I am speaking on behalf of the British Dental Association Scotland. Just for the record, I am feeling really nervous. I have not done much of this before, so I will try not to make a fool of myself.

The main thing that I have to say on behalf of the profession—I suspect that I will sound like a broken record—is that, prior to the pandemic, the Scottish Government acknowledged that the NHS system under which dentists were working was broken, or was not fit for purpose. We were in conversations to try to find a funding model and a sustainable plan to move dentistry forward. That

seems to have been dropped completely, and the worst thing is that there has been very little communication—or at least meaningful, timely communication—between the profession and the Scottish Government. We beg the committee to look closely at that over the next five years, so that we can discuss the needs of our patients and the needs of the profession in a way that allows us to move forward and come out of the dark ages of dentistry, which is how it feels just now.

Dentists will often talk about the treadmill, given that we work piecemeal in a fee-per-item system. The situation was bad before the pandemic, and Covid has really shone a light on the issues. The situation feels particularly dark and difficult just now. Obviously, we want the Scottish Government to look at funding and engagement, but, most importantly, we want it to engage meaningfully with the profession and to discuss the issues with us so that we can help to develop an approach that enables us to look after our patients properly.

Ross Barrow (Allied Health Professions Federation Scotland): Thank you for inviting me along today. I am here on behalf of the Allied Health Professions Federation Scotland. We are a multiprofessional grouping of 12 professional bodies that represent allied health professionals across Scotland. For context, AHPs make up the third largest workforce in NHS Scotland, with a head count of 14,000 staff who are employed across a range of settings, including acute care, primary and community care and social care.

It is a critical moment for all the professions that are represented here today. As we look to recover from the pandemic, AHPFS is looking for recognition of the fact that AHPs have a lot to offer in the current agenda by using their unique skills and training to treat people in all the settings that I just outlined. Critically, that includes treating people closer to home in primary and community care, in order to focus on supporting people in their communities and reducing the burden on acute care—which was significant before the pandemic and is even more significant now—and waiting times for surgery. Allied health professionals are able to offer solutions in the community.

If we could ask for only one thing—it has been mentioned before, and it will be no surprise—it would be to address workforce planning, which is a key issue that affects all our professions.

It affects us all in slightly different ways, as we are a multiprofessional grouping, but, whether the issue is that there are not enough posts for AHPs in particular settings or whether it is that there is a high number of vacancies—perhaps we can get a chance to talk about those issues later today—we really need integrated allied health professional workforce planning. That has not been on the agenda, or at least it has not been addressed in the way that we would like it to be. The AHPFS would be delighted to be part of a solution by offering what we can to alleviate some of the workforce challenges across Scotland.

The Convener: We will look in depth at some of the issues around the workforce and workforce planning. Dr Zamvar is now back with us, so I ask him to finish off what he was saying before he was accidentally thrown out of the meeting.

Dr Zamvar: Hello—can you hear me now, convener?

The Convener: Yes.

Dr Zamvar: I am sorry—when I lost the connection previously, I kept on talking, so I do not know exactly what I was saying when the connection went down.

The Convener: You only got about a sentence in, so you can start from the beginning.

Dr Zamvar: I will tell you what we would like to see in the next five years, if that is what the Scottish Government is planning for. I represent the British Association of Physicians of Indian Origin. We would like race equality and race relations to move up the agenda for the NHS in Scotland. About one third of the medical workforce in Scotland are either international medical graduates or doctors from a black, Asian and minority ethnic background. A significant portion of that major part of the workforce feels that they do not have a level playing field in terms of career progression in the NHS. Differential attainment starts early, during examinations in medical colleges and postgraduate examinations, and it carries on throughout their careers as doctors and consultants in the NHS.

There is a lot of data about that issue from England, but published data from the Scottish Government is missing, or is at least very limited. The recent “Medical Workforce Race Equality Standard” report, which was published in England, looks at the different issues affecting the differential attainment of doctors in the NHS in general and in the academic part of portions of the NHS. I suggest to the Scottish Government that there should be a similar report in Scotland, because such reports bring out the great disadvantage that black and minority ethnic doctors face. That disadvantage not only relates to their employment; it also involves their regulator, the General Medical Council. BAME doctors are referred to the GMC by NHS employers at twice the rate of their white counterparts. Further, the GMC processes and outcomes are, or appear to be, harsher for BME doctors. There are many anecdotes relating to that, including some from Scottish hospitals, but this is not the time or place to mention them.

In the next five years, as we come out of the pandemic and press the reset button, race equality should move up the agenda. In addition, as we catch up with the Covid backlogs, a lot of extra work will need to be done. We would like the staff grade and associate specialist doctors, not just the consultants, to play an important role in that.

Graeme Henderson (Scottish Association for Mental Health): Good morning, everyone. I have been trying to unmute myself—I forgot that you guys are in control of that.

I will address three points that were in the SAMH manifesto on "Standing Up for Scotland's Mental Health", which we shared with most members of the committee ahead of the elections, and then I will deal with a fourth issue, around social care reform.

The first thing that we call for is for children to get help when they ask for it. We still have upwards of 7,000 young people being rejected from child and adolescent mental health services referrals. I know that the Government does not like the term "rejected referrals", but we will continue to use it until there is a change in the system that prevents people from missing out on services.

We would also like an increase in psychological wellbeing support, such as talking therapies. There are still people waiting for months when they have been referred for psychological support. We want a more accessible service so that people do not have to go on waiting lists. We would also like more community support to prevent suicide. We have been supportive of the Government's approach in its document "Suicide prevention action plan: every life matters", and of the work of the national suicide prevention leadership group, which we will continue to support and work with.

With regard to social care reform, Derek Feeley made many recommendations in his "Independent Review of Adult Social Care in Scotland" report, which we very much support. Dr Robertson and Mr Barrow each made a point about the workforce. The social care workforce is under great strain; we have a high vacancy level, high turnover and high levels of burnout. We have people who are off sick long term with long Covid. We are really struggling to help our colleagues in the NHS and local authorities to move people out of hospital. As an example, just the other week we spoke to Glasgow City Council about delayed discharge in relation to 34 people in in-patient psychiatric beds; there is no social care for them to enable them to leave hospital. That situation has a knock-on effect through the whole system. We would like social care reform to involve actual reform, not just tinkering around the edges.

Kate Seymour (MacMillan Cancer Support): Good morning and thank you for the invitation. From a cancer perspective, we have the immediate challenge, which has been caused by the pandemic, of the disruption to diagnosis and some treatment. There is a backlog that needs to be cleared as urgently as possible. Thousands fewer people have come into the system than we would have expected. When more of them come through, they will have more complex needs and, sadly, they are likely to be diagnosed later. That is a huge challenge.

Looking to the next five years, we would like to see effective delivery of personalised care. That involves looking at the full needs of the individual, including their emotional, psychological, financial and practical needs. If we do that well, it will have a very positive impact, not just on the individual but in reducing pressures on the system. It will also help to reduce health inequalities, which are a big issue for us in Scotland. We are very proud of the transforming cancer care programme that we have with the Scottish Government, which is looking to do that in a different way by working with local authorities and the NHS.

We need a radical approach to looking at the workforce. We recently published a report called "Cancer nursing on the line: why we need urgent investment across the UK", which looks at the challenges for specialist cancer nursing. We also need to look at the workforce in relation to a whole-skills mix and at the opportunities that the integration of health and social care in our system gives us. We need to make sure that all the different aspects of the workforce that other witnesses have talked about work together and are really integrated when it comes to planning and delivery.

Colin Poolman (Royal College of Nursing): Good morning and thank you for the opportunity to come before the committee. Our members are telling us that never in their careers have they experienced greater pressure than they have experienced during Covid. We know that it has highlighted long-standing problems in health and social care, including with workforce planning, which has not been up to what we require it to be. We have not been able to guarantee safe staffing levels. Pay and reward are also important, as is the support that we need to continue to put in place for our staff.

11:00

We believe that workforce pressures are key to what you require to look at over the next five years, and that covers a huge number of aspects. If we do not have the correct workforce in the correct place, we cannot deliver what is required for the needs of the population. In the past, workforce planning has been financially driven, but it must be driven by the needs of the population

instead. As colleagues have pointed out, we are at a critical point, but we can look back and learn from the past and not make some of the assumptions that we previously made, which have landed us where we are.

Recruitment and retention get mentioned in the same breath, but they must be split up. We need a recruitment strategy that covers us in the medium to long term, as well as a retention strategy that is sustainable enough to allow us to get through what we are going through just now and to move on from Covid. When we talk about recovery, we have to have much more detailed plans and considerations.

I was struck by the previous witnesses' comments about the importance of listening to the clinicians on the front line. You will not be surprised to hear that, as someone who is speaking on behalf of the RCN, I absolutely support that. If we do not engage with our clinicians and ask them to come forward with solutions, we will not get to where we need to be.

The Convener: Thank you. It has been really helpful to hear from all of you on the general priorities. My colleague Paul O'Kane will direct his first question to a particular witness, but anyone else who wants to comment should put the letter R in the chat function.

Paul O'Kane: I thank the panel for their helpful introductory remarks, which touched on a number of key themes including in particular the pressures that are being experienced in our NHS, the pressure on staff and the staffing challenges that we face.

I am keen to get a sense of what you think about the Government's recovery plan. There have been a variety of responses to its publication. For example, Dr Lewis Morrison of the BMA has said that it is at best "only a start", and I have heard the RCN highlight the point that has just been made about the pressure on staff and whether the plan does enough to address staff burn-out and stress. Dr Robertson, will you tell us what confidence you have that the recovery plan will deliver the required transformation?

Dr Robertson: I mentioned the public messaging around the recovery plan. The Scottish Government has told the public that we can increase capacity to 110 per cent, but as far as we can see, the plan contains nothing realistic that will deliver that or increase the workforce in the short term. New treatment centres have been talked about, but they need new staff. We cannot just move the deck chairs by taking staff from one place and putting them in another, because that will leave no staff at the first place. We just do not have enough medical and nursing staff, AHPs or social care staff. If that is not addressed in the short to medium term, we will not be able to deliver what we are trying to deliver now, never mind increase capacity.

The public messaging makes it harder to be a front-line member of staff. Even before the pandemic, a dignity at work survey that was carried out showed that a third of doctors were suffering emotional and verbal abuse from members of the public. That comes from the public not being told what is really happening and what they can really expect from the service. The people in the service are all working at and possibly past their maximum capacity, and they are tired and exhausted. They feel that they have little control over their work environment, and often the culture that they work in is not ideal, either.

I suggest that committee members consider reading the GMC publication from November 2019 "Caring for doctors, Caring for patients: How to transform UK healthcare environments to support doctors and medical students to care for patients". We could include healthcare and social care staff in that, too, but of course the GMC concerns itself with doctors. If you read the eight key recommendations, you will see that they are based on the three themes of autonomy and control, belonging, and competence—or ABC. That means people having a voice, having work conditions that are appropriate for them, being able to work in a team and having a culture that allows them to feel that their voices are valued. It also means people being able to manage their workload; being allowed to learn, train and develop; being allowed to be part of the solutions; and working as a team to do that. However, none of that can be done if there are not enough staff on the ground.

The plan talks about recruiting people from overseas. That is a longer-term measure. The most important thing that we can do now is to retain the valuable staff that we have and give them places and a system that are better to work in. We will then recruit easily. If we retain our present short-term and medium-term staff, we will be able to deliver the service that we have now. I am not sure that we can deliver any more than we are doing at present, and that needs to be addressed. However, if we retain our short-term and medium-term staff, recruitment will be much easier because the NHS will be a better place to work. That debate goes all the way back to the Sturrock report in 2019, which examined workplace culture.

We need proper workforce planning. There is still a lack of clarity about the plans for GP recruitment. We were told that there would be 800 more GPs by 2027, but we have no clarity on how that is to be achieved. We still do not know what the plan is. If we do not know that, I am not sure

that anybody will, but I would love to know if somebody else at the meeting is aware.

We need more than soundbites; we need action. We need to consider the culture, retain the workforce that we have and involve it in finding solutions.

Paul O'Kane: That is key. Retention has been identified across the board as being important, and successfully encouraging people to stay in the professions is about culture. Does the Royal College of Nursing want to add anything, particularly on the comments about burn-out in the nursing profession? [*Interruption*.]

The Convener: We will just wait for broadcasting to unmute Colin Poolman.

Colin Poolman: Speaking only to oneself is never good.

Dr Robertson is absolutely right. We really need to look at what we need to do to retain staff. We need to allow staff time to rest and recuperate. They have been through a horrendous time and they were already working in a pressured service. That might seem basic, but we need to get back to basics for the staff. We need to think about safe staffing levels and simple things such as ensuring that people have rest breaks and work their contracted hours. We also need to think about offering them a good work-life balance, as well as the support systems that we need to put in place. We are improving the support systems—I have to acknowledge that—but we need to do more.

It comes back to having a sustainable retention plan. We talk about recruitment and retention in one breath and pass over it, but they are two completely different things. We need to think specifically about how we keep people in the workforce. The nursing workforce has nearly 5,000 vacancies at the moment. That is huge. How do we retain in the service the people who might be considering flexible retirement? We need to look at that.

I come from a professional organisation—a trade union—and you will not be surprised to hear that I believe that pay is a major element that we need to consider. Pay for all healthcare workers has not kept up with inflation over the past 10 years. We need to look at that.

I agree with Dr Robertson that we need to work at making the NHS and social care in Scotland places that people want not only to come and work in, but to stay in.

Graeme Henderson: I have been in social care for just over 30 years. I am a registered nurse—I came from the NHS. When I joined social care at SAMH, we had parity of conditions with the NHS or local authorities and our salaries were all tied, typically, to the local authority bandings. Over the past 30 years, that has been eroded. Competition has been allowed to run like wildfire through the social care sector, and we are now mostly paying people on the Scottish living wage. We cannot compete, and we often lose people who go into social work, back into education or into nursing. We have very few nurses working at SAMH. We have about 600 staff. When I joined, we had many nurses and they were on equal pay with their NHS colleagues.

We are not in it for the money, but if our salary conditions are eroded over time, it becomes difficult for people to feel valued as equal partners when they are doing the same work. It is important that individuals in the social care world are given equal value to that of their colleagues. Sue Robertson and Ross Barrow have made points about how we are all in it together and we are all interdependent. We have to work together, and the point about valuing the social care workforce is a really important one.

Ross Barrow: I agree with what other panellists have said about the recovery plan. Of course we need a mobilisation recovery plan—no one would deny that. However, there is an element—sadly—of putting the cart before the horse. What we actually need is a workforce plan, which is what everyone has commented on.

The challenge around the recovery plan concerns the mismatch between patient expectations and the reality of what is happening on the ground. I hope that you do not mind if I run through some examples of that. I am sure that you are familiar with these points, but I want to highlight them. There are people who have gone without treatment during the pandemic because their needs have not been classified as high risk. There are people who have developed complications during the pandemic as a result of shielding, for example, or of being unable to get out and about. There are people who are experiencing long Covid and are suffering due to the challenges of that.

A mobilisation recovery plan is great, but there must be a workforce plan at the heart of it, not only for AHPs but for all the professions and services that are represented round the table. It must identify where we can get the right people at the right place and at the right time to tackle each of the three challenges that I have just mentioned. I reiterate that a mobilisation recovery plan is great, but it needs to be fully integrated with an understanding of where the workforce pressures and needs are. From an AHPFS perspective, that is where we would like to start.

Sandesh Gulhane: We have heard from Sue Robertson—and indeed from the whole panel—about the difficulties that we have with staffing. Adding race inequality on top of that makes life for

BAME staff even worse. What can we do to improve race equality in our NHS?

Dr Zamvar: We should talk about it and acknowledge that there is a problem, or at least a perception of a problem. That would be the first step. I do not know how many of you have seen the "Medical Workforce Race Equality Standard" report, which was produced by NHS England just last month. There is a race equality report for all NHS staff, but the MWRES report focuses on the medical workforce and it has brought out the stark inequalities that BAME doctors face. As a first step, we should do something similar in Scotland. That would mean that we at least knew what the problem was so that we could start to address it.

My second suggestion is that we look at why NHS employers refer BAME doctors to the GMC more often and whether anything can be done to solve the problem at trust level rather than it having to go to the regulator—the GMC. Those suggestions would help to address the problem.

11:15

The Convener: We will move on to discuss Covid-19 and the backlogs, on which Emma Harper will lead.

Emma Harper: Over the past few weeks since the recovery plan was published, we have heard that there will be a need to address backlogs in the diagnosis of cancer—including breast and bowel cancer diagnostic processes and cervical smear tests—ophthalmic surgery and cataract treatments and hip and knee replacements. How will we address that demand? During the pandemic, elective work basically stopped. Even now, the intensive care units are filled with Covid patients rather than, for example, elective bowel surgery patients. Where do you think that the backlog of surgery requirements and diagnostic testing needs to be tackled?

The Convener: Who would you like to answer that first?

Emma Harper: Dr Sue Robertson.

Dr Robertson: It is a massive problem. We were under great strain before the pandemic. We have changed the way that we do everything, at least temporarily, and some of those changes will remain. The backlog of people who are waiting for elective surgery is huge. For example, last week I was told that, in my region, it will probably be about 70 weeks before somebody who clinically needs a hip replacement, because they are being woken up by pain every night and are on the maximum dose of painkillers, will get one. That is a long, long time. That will increase the morbidity that they will suffer as a result of taking painkillers and their lack of mobility. During that 70 weeks, they will probably feel quite hopeless. They will probably have to go on more and more painkillers, which may have adverse effects on their health. They will get less and less active, which will impact adversely on their health. It will mean that they may well go rolling down the hill of health before they get their hip replacement, and they will then have to climb that hill again.

It is a massive problem, but we do not have the facility or the staff to meet that demand. We only have the staff to do what we were doing anyway, and everybody was working to the maximum. We must retain staff and increase staff numbers. I am talking about not only doctors but all of us who deal with patients who are in the position of waiting for what we call elective surgery, but which they probably feel is urgent surgery, because they are in pain. Without bringing in extra staff and stopping existing staff feeling as though they need to retire because they cannot do their job any longer, as it is having adverse effects on their health and their family, we will not be able to deliver the increased capacity that we need.

Therefore, it is not simply a case of building treatment centres and doing all the elective surgery there. As I said, it is a very complex and difficult problem. If we are to address the backlog, we might have to stop doing some of the things that we do at the moment. That will require a societal discussion and honesty—there needs to be honest public messaging about what we can do, not what we might wish to do, and what we can deliver over the next five years.

Being honest with the public is key. That will allow the public to be part of the debate, but it will also protect front-line healthcare staff, who are often abused by members of the public because they do not understand why we are not doing what they feel we should be doing. We are all working to our maximum.

Kate Seymour: I will build on what Sue Robertson has said. There are pressures on all parts of the system. If someone has had their cancer diagnosed late because of the pandemic, it is likely that they will have had their diagnosis through attending an accident and emergency department, so there are increased pressures on the emergency part of the system. Those people's needs are more complex, so they might need more input from AHPs or from people in other professions. There will also be impacts on palliative and end-of-life care, because more people will be diagnosed at a later stage. We have to think about the issue from a whole-system perspective, because there will be pressures everywhere. There is a need for additional resource everywhere in order to make the system work well.

I go back to the importance of integrated thinking and workforce planning, so that we reduce pressures when we can and ensure that people's needs are dealt with by the most appropriate part of the health and social care system. That is a huge challenge. The most obvious example is when we talk about bed blocking. We have to be better at such planning if we are even to begin to address the resource challenges that we face.

Donald Morrison: I am probably repeating what has been said, but one of the most important things for us to highlight, as health professionals, is that oral cancer is one of the cancers that is picked up asymptomatically. It is picked up through regular screening. Scotland has one of the highest oral cancer rates in Europe. The treatment of the cancer in its early stages is relatively simple, but the sequelae of it are horrible disfigurement and quite drastic and difficult surgery. The imbalance between the two is a major reason for screening patients and seeing them regularly, which we cannot physically do just now.

People from a deprived community are twice as likely to die from oral cancer in Scotland, so the inequalities gap will grow larger and larger. We are only at the tip of the iceberg; in the next 18 to 24 months, the problem will come home to roost. I am very concerned that we are not even feeding people into the system yet because of how screening works and because we do not get to see them.

The Convener: To clarify, do you pick up signs of oral cancer during check-ups and more routine dental work? Is that how you spot it early?

Donald Morrison: Not only is that how we spot it early, but people do not feel it when we find it. Often, someone presents with something and says, "This is a bit sore. I've noticed it. Can you do something about it?" The dentist looks in the mouth as a routine and sees a lesion. They ask the patient how long they have had that for, and the patient says, "I haven't even felt it. I didn't even know it was there." The dentist then says that they will look at it in a couple of weeks. If the issue is unresolved, it is put in the system, oral surgeons see it and a biopsy is done. The cancer is found, scanned and removed in the space of six to eight weeks.

If the cancer is left untreated, the patient does not always feel very uncomfortable, but, by the time that it has spread, a radical neck dissection and major chemo are needed and the patient will be deformed by the surgery. All those things go into treating someone with hidden neck cancer. Through the screening process and seeing patients every six months, we can detect the cancer and treat it very early. Now, every time that a dentist has a patient in front of them, for whatever reason, they do the screening and try to keep that going. However, 4 million attendances were lost last year through Covid. We lost so much but, yes, oral cancer can generally be detected just through looking in the mouth.

The Convener: I will come back to Emma Harper in a moment but, first, I will pick up on something that Dr Robertson said around what patients can expect. It is a difficult line to tread because, on the one hand, during lockdown periods, people who really should have engaged with their health professionals did not do so, because they were worried about adding to the stress, but we are all seeing in our inboxes that the public might now be expecting more than the services can give. How do we strike that balance and manage patient expectation?

Dr Robertson: I think that we have to have honest conversations with the public. At the moment, we are almost in a place where the people who shout loudest get what they want.

As I said in the chat, I work in an admissions unit, where we see patients who have not wanted to bother anyone because they know that we are really busy. However, as a result, we see them further down the line of their illness trajectory, so they need more powerful drugs or more major surgery than they might have done otherwise. Therefore, it is about having that conversation with the public about what we can deliver and the fact that the people who shout loudest are not necessarily the ones that get the care, because the care has to be delivered on clinical priorities, not on who complains loudest. If we are to be the caring, equitable society that we want to be, we have to have that societal conversation.

The Convener: If it is not done carefully, it could exacerbate the problems, so what are your thoughts on the role that politicians and, by extension, the media—because that is where a lot of the messaging lies—need to play in that honest conversation?

Dr Robertson: At the moment, it is almost as though we are working against the politicians and the media. It feels like we are trying to deliver the best care that we can but then we see that, for example, the big headline for the NHS recovery plan is that we will increase service to 110 per cent. We ask politicians to engage with us and the other organisations that are represented in this evidence session, so that we can work out how best to message the public. We need to take the approach away from vote-winning or vote-losing decisions and towards what is best for our society and the individuals within it. It has to be a long-term, societal conversation about where there is a match between what can be delivered and what people are demanding, where there is a mismatch, and how we address that, perhaps in other ways.

The Convener: Thank you, that is very helpful. Before we move on to talk about staffing more generally, Emma Harper has a quick supplementary question.

Emma Harper: I will try and be quick. In the last session of Parliament, we did a report on social prescribing. We can keep people out of hospital in the first place by engaging them in practices that support health, wellbeing and physical activity, thereby preventing complications of type 2 diabetes, because 10 per cent of the NHS budget is spent on mitigating those complications. I am interested in what the witnesses think and I suppose that the convener can choose someone to answer the question.

The Convener: It would be good if you could choose the person to answer the question, Emma.

Emma Harper: What value do we need to place on social prescribing, in order to stop folk people getting poor health in the first place, as well as support work such as pulmonary rehab and mitigation of type 2 diabetes complications? That question goes to Dr Robertson again.

11:30

Dr Robertson: We probably need to step back even further. I listened to the first panel, in which Sir Harry Burns talked about poverty and health, helplessness and hopelessness. We need to consider the health of the population and try to improve it in any way that we can through giving people opportunity and support, and making them feel like valued members of society.

We also need to increase the possibilities and the encouragement for people to be more active and live healthier lives—Emma Harper knows that I would say that, because I am a big physical activity person. However, people need to have the opportunity to do so, so we need to consider how every policy impacts on health, as Sir Michael Marmot said. For example, we need to consider the built environment and build schools in places that children can walk and cycle to, so that walking and cycling becomes the norm. When children walk and cycle, then the parents walk and cycle and become healthier, reduce their risk of type 2 diabetes and other diseases, and improve their lung health and general health.

We need to consider health in all our policies. Only by doing so can we shift around the big oil tanker that is our unhealthy population to make it more resilient and healthier the next time something like Covid comes around, so that people are less likely to become ill or to die of some other illness that will attack the least healthy in our society.

Graeme Henderson: A number of years ago, the Government funded the Health and Social Care Alliance Scotland and SAMH to test out link workers in primary care services in Glasgow. Those link workers are social prescribers, who link people to things that are happening in their communities. Many of those activities are physical, but people can partake in many other activities that would benefit their health.

The pilot, which described the training and the approach, and the lessons that were learned, was written up and then went out to local authorities. I asked Public Health Scotland for information on the matter, as I am aware that we have a variety of different approaches to link working, because of tendering processes: some local authorities have band 7 nurses who carry a case load; others have Scottish living wage third sector workers, who do not carry a case load.

There is a lack of consistency across Scotland in our approach to link working, which is confusing for patients and workers. We have missed an opportunity to learn and implement the lessons from the pilot. I do not argue against local democracy, but perhaps the Government could have been a bit more robust in its guidance to local authorities about link working, based on that pilot study from some time ago.

Kate Seymour: I totally agree with the point that Graeme has made, which is why MacMillan Cancer Support set up a transforming cancer care partnership with the Government, in which link workers in local authorities support people with all their needs around cancer. Obviously, those services are just for cancer patients, but that is what that model attempts to do.

I completely agree with Sue Robertson on the need to improve the general health of our population. Equally, however, it is not too late to act once someone is in the system and has ill health. Once a person has had a cancer diagnosis, we do a lot of work around prehabilitation. We also consider all areas of support in relation to their physical activity and financial needs, and also their emotional and psychological wellbeing. If we can give people that support through their cancer journey, it becomes less likely that they will come back into the system through an emergency admission or just because their health has deteriorated due to their cancer treatment.

Although getting in earlier is key, it is never too late. However, when someone receives a major diagnosis such as one of cancer, that is often a good point to look at interventions such as social prescribing and other supports, in order to improve people’s health through that and lessen the likelihood of them needing more support later.

The Convener: A number of members want to dig deeper into the staffing issues that all the witnesses have raised. I go first to David Torrance.

David Torrance: The panel members have talked about recruitment vacancies in the NHS. I think that Dr Robertson mentioned that it can take years to recruit from abroad, and Brexit has not helped with that. How do we make the NHS attractive for people to retrain for, and how do we encourage school leavers to consider working in the NHS as a career path?

The Convener: Is that directed to Dr Robertson?

David Torrance: Yes—sorry.

Dr Robertson: As I said, retaining the workforce is the first thing. If you can provide a place of work that makes people feel valued, supported and included, you will retain the workforce. It is about workforce culture and workload. The GMC paper that I referred to sets out how to improve the work environment for doctors and gives an ABC of their needs. The A involves giving people autonomy and control so that they have some sort of influence on what happens around them and how their service is delivered. The B is that they need a feeling of belonging, which requires improved teamworking, culture and leadership. The C is competence, which means that we need to provide an environment that allows doctors to manage their workload appropriately and that gives them appropriate supervision and the ability to learn, train and develop.

On top of that, you have to pay people well enough for the job that they do. That goes not just for doctors, but for everyone. Many of us have had our wages go down in real terms over the past 10 years. We want the brightest and the best in the NHS and in social care. We want people who really want to be there and who will give a piece of their life force to each patient to help them get better. However, you need to give those people a place to work that does not impact badly on their health and leave them—as evidence has suggested the current situation does—feeling that they have no energy left for their families and loved ones, because they are so burned out from working in the environment that we work in at the moment.

If people want to stay in their job because they want to work in that workplace, they will immediately tell school leavers that it is a great place to work. They will say, "Come and work here. You will feel valued. You will able to innovate and develop, and be part of improving service and developing things as they go forward. You will be financially valued and personally valued."

You need to provide workplaces that have facilities for decent rests in breaks. You need to look after people when they are tired and give them a place to lie down so that they do not have to drive home after a night shift when they are too tired, thereby preventing them from having a crash on the way home. We need workplaces that leave people feeling that they still have compassion left for their families, their loved ones and themselves. If you can provide workplaces like that, school leavers will want to work there. Society will say, "This is a great place to work. You should want to come here." People in the job will not be saying, "I can't do this any longer. I'm not at retirement age, but I need to find a way to get out of it and do something else."

The whole thing stands and falls on value. If people feel valued and supported, they will feel well. Harry Burns said that we can create wellbeing by creating an environment where people feel safe and supported—I would add that they need to feel valued. If you can do that with the NHS and social care, you will have no problems with staffing levels. If you can be realistic with the public about what they can expect of the people who are trying their best at the moment, and if you can talk about being gentle to those people, you will make it a better place to be. That will mean that people will stay, they will develop the service, they will make it better and we will be in a better place in Scotland.

The Convener: Other members wish to ask questions. I remind all panellists that, if you have anything to contribute on the issues that come up, please just put an R in the chat box. I will get notice of it and I will come to you.

Gillian Mackay: Following on from Dr Robertson's contributions, I am particularly interested in staff morale and wellbeing. Are clinical and other staff getting enough support? What can be done in the immediate short term to prevent a crisis of morale? What could be done in the long term to improve overall recruitment and retention in each of the groups that you represent?

Dr Zamvar: If we can create a workplace just like the one that Sue Robertson described in answering the previous question, that would go miles towards improving staff morale. Better financial rewards do not provide the whole answer; there is a resource crunch, too. It is about making people feel valued and being realistic, at least, with all the staff about what they can expect from the workplace.

Graeme Henderson: To echo Sue Robertson's point about value, it is not just about financial value; it is about status as a worker and as a sector that is valued by the public and politicians.

For example, in the past 18 months, we have brought in an additional two days of annual leave, which are called wellbeing days. They are specifically addressed to wellbeing, because we value people's wellbeing and we want people to take time for their wellbeing, not just for their holidays. We have also given every individual staff member a £100 wellbeing budget for them to use for whatever they want.

Obviously, that costs money. SAMH has the capacity to do it, but a lot of our third sector colleagues do not. There is the money to pay people, but we also need money in the system to give organisations capacity to do things such as what I have just suggested.

Ross Barrow: On the question about improving morale, allied health professionals, like all health and social care professionals, care passionately about the work that they do and about using their skills to provide the best care. One way that we can improve morale is by ensuring that we have the right healthcare professionals in the right place at the right time.

We talked about backlogs. Allied health professionals all have the ability to asses, diagnose and treat, and to work as first-point-of-contact practitioners within primary and community care. If they are put in the right places because there is enough workforce to support that overall package across the system, instead of a patient being on a waiting list for 12 to 18 months, they will be seen immediately by an allied health professional or someone else in primary or community care, and they can get immediate access to treatment. It will be such a bonus and will give a morale lift if people can do what they came into the profession to do.

On staffing, Mr Torrance asked about how we raise awareness of the professions in schools. There is a lot of work to be done by all the stakeholders to raise awareness of allied health professions and the range of things that people can do in their careers as an allied health professional.

There are a couple of things that we could do from a policy perspective to improve the different routes into training. The introduction of degree apprenticeships for allied health professionals is very important. We do not currently have that in Scotland, although it is available in other parts of the UK. We should also consider bursaries to incentivise people to come into particular professions that are struggling to recruit over a longer-term basis.

Finally, return to practice is an important part of the jigsaw. It is about how we incentivise people who might not currently be working in health and care but who have really good skills and could come back into the system, and how we can support people with good-quality continuous professional development and training so that they can really make the most of that and can contribute.

11:45

The Convener: Paul O'Kane has a question. I am aware that other witnesses want to come in. I am bringing in members to put some other things into the mix, and then the witnesses can pick up on any of the issues that have been raised.

Paul O'Kane: I would not disagree with much of what has been said about the real pressure on staff.

I am interested in our immediate crises, and particularly in the onset of winter and winter pressures across the piece. Obviously, there is long-term workforce planning, but there is clearly an immediate need, particularly in acute settings, when it comes to how we physically keep the show on the road. We are seeing a lot of pressures at the moment, and we are not even at peak winter yet when it comes to admissions and use of service.

I am therefore keen to understand what is needed and what can be done to increase resources and staffing right now, and what would make most difference. I appreciate that that is not easy to answer, but I am keen to get a sense of that, possibly again from Dr Sue Robertson or the RCN, although I can ask everyone, I suppose.

The Convener: I will come to Colin Poolman first and then to Dr Robertson.

Colin Poolman: Thank you—I have been keen to come in.

I agree with most of what has been said in relation to everything that we need to do on environment, culture and support for staff. Morale is clearly under huge pressure at the moment. Mr Torrance asked what we need to do. We need to work through what is an incredibly difficult time. Nobody has all the answers.

It comes back to the issue of the conversation that we have to have with the public. We have the unintended consequences of longer waits and people wishing to be treated, but we also have the pressures of the system. We get that every day, and we see it in the media. It is about allowing our health and social care employers to work with their staff and to be honest about what we can provide. We need to work that through in sustainable planning and, when we cannot do something, we need to be very clear about why we cannot do it.

It comes back to the pressure on staff, who read in the papers that we have to do X and Y, when

they know what the reality is. We need to come back to that reality and say what we can provide now and why we have those pressures. At times, that will mean that we need to reel back what we can do, because we need to use the resource that we have, as well as looking in the short term at every possible avenue for bringing back into the service the people who wish to be there. That will include providing free training and support, and looking at other ways of staffing so that we are not just putting increased pressures on the existing workforce.

The more that we ask the existing workforce to do extra shifts to cover, for example, for a big increase in sickness, the more pressure and absence there will be. That will add more problems, especially as we go into winter. Our members are telling us that it feels like winter right now, in the middle of summer.

We need to do all those things, but it comes back to the really hard public message from the NHS and from social care—and from the media and politicians—about what, honestly, we can provide currently, and saying that we are doing everything that we can to move forward in the future. It is going to be a difficult road.

Dr Robertson: I absolutely agree with everything that Colin Poolman just said. Public messaging is absolutely key. That is the bit that we are not in control of—we are not in control of what the public are told; all we can do is try to deliver the best service that we are capable of delivering. The messaging needs to be done centrally, it needs to be done honestly and it needs to engage the public.

As to what else can be done right now, we need better pay in social care so that people take those jobs and stay in them, instead of taking a job as a carer and then finding that they could earn twice as much stacking the shelves in Aldi. We need to value social care for what it is, which is the bedrock of all this. If we get social care right, we can be a national health service that delivers what is needed. People can stay at home if they want to, with appropriate care, or they can access appropriate care facilities if they need them. If we get all that right, we will take a massive amount of pressure off the NHS, and people will be happier. People do not want to be in acute hospital unless they absolutely need to be. That is another key message.

The need for better information technology is a huge issue. It is a constant bugbear for all of us that the IT that supports our work is glitchy and not as good as it could be. We have lots of young people working in the service who have lots of really useful suggestions about how we could improve our IT to make it easier and quicker to do our jobs. It is about asking people who are doing the job how we could support them and what we could put in place for them to do their job better.

We also need to increase the number of nursing staff, AHP staff and other members of staff around us to do jobs that we do not absolutely have to do, so that we can do the things that only we can do. For example, having a dietician in my team allows me to refer to them to ask about nutritional requirements for a patient to keep them well while they are in hospital with an acute illness, so that they will be well when they go home, instead of having slipped a little bit down that hill.

In relation to physiotherapy, pharmacy and all the other parts of our healthcare team, we need the ability to work as a team and the connectivity to work together with primary and secondary care. All those things could be addressed now.

The culture within organisations is another issue. In that regard, I signpost the committee to NHS Dumfries and Galloway. We are part of the prosocial health project, which aims to improve teamworking, personal wellbeing and culture in our organisation. It was set up by our psychologists, but I am part of that group. People from operational development, learning, psychology, medicine—me—and our spiritual lead are all working together to help teams to improve the culture where they work and consider and improve the way that they work as teams.

Lots of work can be done. However, people need to be given the time to do it. It is almost a spend-to-save situation—if you give people time now, it will absolutely save time in the future.

The Convener: I will go to Donald Morrison and then to questions from members. I ask members to direct their questions to the individual from whom they want an answer, because we are rapidly running out of time, as I knew we would.

Donald Morrison: I will try to be brief.

On recruitment into the NHS in dentistry, one of the big problems in relation to the hit of Covid is that it affected extremely heavily the university intake and the qualifying dentists coming through. In essence, we lost a cohort—or they were sent back to do another year of study.

In addition, in Dumfries and Galloway—which Sue Robertson mentioned—more than 40 per cent of dentists are from outside the UK, so I do not know how Brexit will affect us. Although we have not seen a drop-off of registrants, the general feeling from practitioners is that anybody of retirement age will try to retire soon. We do not seem to have an immediate influx of dentists from outside the UK, and we have a backlog of training.

The dentists who are coming into the profession are in a position in which there is not really any funding in the classic sense. High-street dentists

are not salaried. We have talked about various issues today, and, of course, patients are the priority, but it is important to point out that 95 per cent of dentists do a mix of NHS and private dentistry, and the set-up is geared against them working for the NHS. The funding for them to continue to work has been reduced by 15 per cent, although there is also reduced activity.

However, the process that they have to put in place means that it takes four or five times longer to do each unit of work—such as giving someone a filling—but they get the same money. That puts such stress on the workforce that they do not want to work in the NHS, and means that it might not be financially viable for them to do so. The luxury that a dentist has to spend a lot of time looking after their patients and seeing as many as possible is lost when they have to make a business that continues to be viable.

Sometimes, dentists can feel like they are in a Cinderella service, because they run small and medium-sized businesses as an annexe of the NHS. We work hard for our patients and want to do all that we can for them but, ultimately, the perfect storm of there not being enough sustainable future funding and there not being a model that we can all work with and understand will mean that we will lose dentists in the NHS hand over fist.

The Convener: I invite Sue Webber to ask a question. I remind you, Sue, that it would be good if you could say to whom your question is directed.

Sue Webber: Earlier, we heard that all policy should be focused on healthcare, and we have heard from members of the panel that workforce planning should come before a remobilisation plan. We have also heard about the diverse careers that are available to people in health and social care—including dentistry; I will not ignore that one.

My question is for Sue Robertson, given that we have a short timeframe. Is the cap on Scottish young people getting into medical schools and universities in Scotland negatively affecting long-term recruitment and our ability to create a sustainable workforce plan?

Dr Robertson: The question requires something a little more complex than a yes or no answer, I am afraid.

There is no doubt that we have very many able school pupils who would make good doctors and who want to do medicine. However, we must also have the ability to train them. Without the workforce to train those young, developing doctors, there are issues around removing the cap. We know that school pupils from Scotland are more likely to work in Scotland in the longer term, so that is a tick, because we want more school pupils in Scotland to do medicine and stay with us. At the moment, if we increase the number of medical students in total, there is a significant risk that there would be not enough doctors to train them and help them to develop.

One of the main things that we need to consider is the number of doctors who go elsewhere after the first two years of their practice. Research suggests that around 40 per cent of young doctors go elsewhere in the world after doing their foundation years in Scotland. Scottish medical training is high quality and is respected around the world. That is a good thing, but if we lose half our young doctors to other countries because, having had experience of the healthcare structure that we work in, they decide that they do not like the culture and the way in which doctors are treated, or they do not feel that their opinions are valued, we will face the same problem. If they are to stay, we need there to be a workplace that they want to work in.

I absolutely want more young people in Scotland to be able to do medicine, but only if there are enough doctors to be able to train them appropriately while also providing the healthcare that we need to provide. Further, I want there to be a workplace that those young doctors would want to stay in.

12:00

I applaud the Scottish graduate entry medicine courses, which are increasing the number of young doctors born in Scotland who want to work in general practice or psychiatry—areas in which we definitely need more doctors. I support increasing the diversity of people who become doctors and looking at how we pick people for medical school and at how to increase the availability of medical school places for people who have perhaps not had the best opportunities in life in school and so might not have quite as good a CV as someone who has had the best opportunities. We want more young people to do medicine, but we want them to be able to do medicine while looking at working as doctors in NHS Scotland and seeing that as an attractive career, rather than training in Scotland and leaving because they see how burned out their senior colleagues are when they experience time on the wards or in general practice.

Stephanie Callaghan: I thank everyone for their contributions today. I want to ask about the role of technology, which I will come at from two angles. I have had conversations in which I was told that not all the NHS vacancies could be filled at the moment and that more things need to be done with fewer people, which is about the rapid adoption of technology to help in that regard. One of the examples that I was given was about

radiology, where there is an artificial intelligence diagnosis but the radiologist does the more complex work. That issue is for Dr Zamvar to consider.

The other issue is preventative care, which possibly Ross Barrow could consider, with regard to bed modelling to keep people out of hospital and look after them at home, or to get them out of hospital more quickly when they are in hospital. It is about the use of technology practices that might help colleagues advance their career by taking on more complex roles. The question is how they would do that.

Dr Zamvar: We definitely need better technology. For example, I have lost my wi-fi so many times this morning. Ms Callaghan mentioned AI for looking at radiology scans and so on. A lot of work is happening in that area, with reports coming mainly from US hospitals that are using that technology. It is possible to use it, and we should consider doing so. However, whenever we introduce new technology, it always costs more money. Pilots might show that it saves money, but it will eventually take over and will cost more. However, that should not prevent us considering using the technology, because it saves time in the long run and will save misdiagnosis in some cases as well.

What was the next part of your question?

Stephanie Callaghan: It was about doing more with fewer people.

Dr Zamvar: We should be open to ideas on that. For example, I am a cardiac surgeon and practitioners in our department are now doing more ward rounds. We also have surgical care practitioners assisting us in operations, which means that we do not need an assistant surgeon to assist us in operations. That has been happening for a number of years, but given the problem of staff shortages this year because of Covid, we should pay more attention to that issue and say what roles staff can undertake to ensure that we have more time to do other things. That is definitely possible in surgery.

The Convener: I bring in Ross Barrow to comment on Stephanie Callaghan's second point.

Ross Barrow: There are a number of issues around that. The first is on how we do more with fewer people, which relates to self-care management and working with patients and service users to ensure that they understand their own healthcare needs and feel that they are an agent for change in that regard. It is about seeing the healthcare professional as an expert guide and allowing the patient or service user to be seen as a partner who is in control of a lot of interventions.

As for technology, which you asked about, there has been talk of an NHS app that people might be able to access on a tablet or their mobile phone. That presents a massive opportunity in a number of ways. For example, a lot of self-care management advice might be, say, exercise videos or guidance on things that people can do when they come out of hospital after elective surgery. People will still need support from healthcare professionals, but a lot of information can be given directly to a person via their mobile phone or tablet. Of course, that will not be the case for everyone, and we have to be careful with regard to that section of the population in Scotland who are digitally excluded. For some people, though, such a move might be a good opportunity.

The Convener: We are rapidly running out of time, but I want to bring in Evelyn Tweed, who has a specific question for the panel.

Evelyn Tweed: We have talked a lot about the health and wellbeing of our healthcare staff and professionals, but what can we do immediately to support them, give them a listening ear and ensure that they know that they are valued? A lot of the things that we have been discussing are quite medium to long term, and I would like to hear what we can do right now.

The Convener: I guess that a number of witnesses will want to address that as a final question, so could you tell us whom you are directing it to?

Evelyn Tweed: Perhaps Dr Robertson could go first.

Dr Robertson: For starters, we can listen to the people in their teams. Management and senior management can listen to and value the opinions of those who work on the front line and have boots on the ground. That is key. The fact that you are listening to us is excellent, and it makes me feel that our opinion is valued. It is amazing how far that sort of thing goes.

Our psychological services for staff are gradually improving. Access to psychological services at all levels for all staff who are involved in health and social care is absolutely key, too, and a lot has been done during Covid to shift that forward quite considerably.

There are also simple things that can be done such as having a space where patients and their relatives cannot go and where staff can take a proper break. After all, if staff can have that kind of physical and mental break, they feel stronger when they go back to their shift. Other things that could be done include making hot food available at night to those on the night shift when they go on their break or giving them somewhere to lie down and have the 20-minute power nap that we know will improve their decision making, reduce their

compassion fatigue and make them a better team player. The provision of rest facilities and psychological support and the valuing of people's opinions are all things that could be done right now.

I also come back to the issue of public messaging. We need to send out the message that the people on the front line are doing their best. They did not design the service, so they should not be abused by people when the service does not work for them. We also need to support staff who face abuse by taking a zero-tolerance approach to such things in the health service and in social care.

Those things can be done right now to make staff feel supported and safer in their roles at what is a really difficult time. As has been said, we do not need to wait for winter to see how much busier things are; in fact, I do not think that I have felt things to be so overwhelmed in my 35 years as a doctor—that is happening now. We are therefore really worried about winter. A lot of staff will be just on the edge of their ability to cope, and it will not take much to tip us over. If you can put in the kind of support that I have described and say, "We value you enough to give you hot food at night and to give you a rest space where there are no patients or relatives", it can go a little way to making people feel that they are valued members of a team and, indeed, a big system and that someone has their backs.

The Convener: Thank you. I am afraid that we have time to hear only from Donald Morrison and Graeme Henderson. If other members of the panel have anything else to say or feel that anything has been missed, they can, of course, email us and let us know.

Donald Morrison: I do not want to be the one to say this—I like to be as positive as possible—but on the question of what we can do now, I would say that, as far as dentistry is concerned, the issue is more about what should not be done. Going back to the point that Sue Robertson made about increasing capacity to 110 per cent, I simply note that, when the decision was taken to wheel out free dentistry to 18 to 26-year-olds, we found out about it 24 hours beforehand. It is just a simple thing that we want, but the fact is that such things are not being discussed or worked through with the profession, which feels that it is not being communicated with.

We should also not say that this is just business as usual, because it clearly is not. Our members are having to work in what is a very stressful situation while the message to the public is "Get on with it—it's business as usual." That is just not the case, and if we could address that one issue, it would be really helpful.

Graeme Henderson: I just wanted to mention the time for you service, which is a three-tier psychological intervention for front-line workers that SAMH developed and set up last year. It is directed mainly but not exclusively at shop workers, drivers and social care workers; actually, it is available to everyone, and just over 400 people have registered for it.

The service, which has been developed in partnership with Glasgow Caledonian University, uses its trainee psychologists to offer psychological interventions. It does not cost a lot of money—about £150,000 a year—and can accommodate up to 4,000 people. I should also say that it uses an online cognitive behavioural therapy-based approach called living life to the full. It is a low-cost, accessible service that has worked really well over the past year.

The Convener: Thank you very much. I thank everyone on the panel for their time this morning. I am sorry that we do not have more time to hear your views, but what you have told us has been very useful.

Subordinate Legislation

National Health Service (General Medical Services and Primary Medical Services Section 17C Agreements) (Scotland) Amendment Regulations 2021 (SSI 2021/302)

12:12

The Convener: Agenda item 5 is consideration of a negative instrument. The purpose of these amendment regulations is to fulfil a commitment to general practitioners to remove the general requirement to provide certain vaccinations from their general medical services contracts and primary medical services agreements with health boards and to ensure that GPs' contracts will only require them to provide vaccinations in exceptional circumstances.

The Delegated Powers and Law Reform Committee has raised no issues with us on the regulations and no motions to annul have been lodged. If members have no comments or points to make, I propose that the committee make no recommendation in relation to them. Are we agreed?

Members *indicated agreement.*

The Convener: At our next meeting, on 28 September, the committee will host two round-table sessions with key stakeholders to explore session 6 priorities in relation to social care policy and health finance respectively.

That concludes the public part of the meeting.

12:13

Meeting continued in private until 12:40.

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