OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Recovery Committee

Thursday 11 November 2021

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 11 November 2021

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COVID-19 RECOVERY COMMITTEE
10th Meeting 2021, Session 6

CONVENER

*Siobhian Brown (Ayr) (SNP)

DEPUTY CONVENER

*Murdo Fraser (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*Jim Fairlie (Perthshire South and Kinross-shire) (SNP)
*John Mason (Glasgow Shettleston) (SNP)
*Alex Rowley (Mid Scotland and Fife) (Lab)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Andrew Buist (British Medical Association)
Dr Donald Macaskill (Scottish Care)
Donald Morrison (British Dental Association Scotland)

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

COVID-19 Recovery Committee

Thursday 11 November 2021

[The Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Convener (Siobhian Brown): Good morning, and welcome to the 10th meeting of the COVID-19 Recovery Committee in 2021.

Item 1 is a decision on whether to take in private item 4, which is our approach to the proposed coronavirus (discretionary compensation for self-isolation) (Scotland) bill. Do members agree to take that item in private?

Members *indicated agreement.*

Baseline Health Protection Measures

09:30

The Convener: The committee continues its enquiry into baseline health protection measures, taking evidence from stakeholders in health and social care services. I welcome to the meeting: Donald Morrison, a member of the British Dental Association Scotland's Scottish dental practice committee; Dr Andrew Buist, the chair of the British Medical Association's Scottish general practitioner committee; and Dr Donald Macaskill, the chief executive of Scottish Care.

I thank the witnesses for giving their time to us this morning. This is the second of the four evidence-taking sessions that we have planned on baseline health protection measures. Those measures are the main tools that we are using to respond to Covid-19. They include ventilation, face coverings, social distancing and vaccinations. Today's meeting will focus on the role of baseline health protection measures in keeping health and social care services running over the winter. We will also consider what long-term support might be required to support the sector to recover.

Will the witnesses briefly outline the continuing impact of Covid-19 on their sector? Are we using the right approach to baseline health protection measures to help us to get through the winter?

Donald Morrison (British Dental Association Scotland): I am a general dental practitioner of more than 20 years' experience in the national health service. I currently work in a mixed NHS practice in Ayrshire, which is responsible for 5,000-plus NHS patients.

You ask how Covid has affected the sector, convener. Statistics show that we have lost more than 4 million appointments since the beginning of the pandemic. The system was working at 100 per cent capacity and groaning at the beginning but now, due to the mitigations that were introduced to protect patients and clinicians—the different baseline measures—surgeries probably, even at their absolute best, work to only 40 to 50 per cent of what they did before. By definition, a system that was creaking before is absolutely struggling now and it will be a few years until we get back to anything like normal.

There has been a lot of support from the Government for the NHS part of the sector. Support payments and recovery packages have been put in place to try to keep practices running, without which they would generally have gone to the wall. However, the system is struggling hard to keep up at perhaps 50 per cent of what it was.

Although we have had help, the most important point is that, from here on in, we need to think carefully about how the sector will be affected when we try to get back up to the percentages of care that were offered in the past.

Dr Andrew Buist (British Medical Association): As in dentistry, our capacity has been affected by the baseline measures. We have dealt with that, as we did from the beginning of the pandemic, by moving to what we call a hybrid method of consulting, with a mixture of remote consulting by video or telephone and face-to-face appointments.

By doing that, we have managed to maintain the totality of the number of consultations that we offer. We surveyed practices in Scotland four weeks ago, and that showed that we are providing more than 500,000 appointments each week, with a mixture of remote and in-person consultations.

The baseline measures have undoubtedly impacted on how we work. They include social distancing as well as mask wearing, which I find particularly difficult when consulting, although probably not as difficult as dentistry does, for obvious reasons. Seeing a patient face to face is such an important part of the consultation, because of the non-verbal clues, particularly with mental health issues. I have tended to cope with that by seating a patient at a 2m distance and asking whether they agree that we take off our masks so we can see one another face to face.

Overall, the measures have impacted on the service that we offer, but, by providing a hybrid model of consulting, we have managed to maintain overall totality of consultations. However, that has come at a significant cost to the general practice workforce, who are quite fatigued by that and by some of the unfair criticism that has been levelled at general practice.

Dr Donald Macaskill (Scottish Care): Thank you for the invitation to the committee. The social sector has been particularly hard hit by the different waves of the pandemic. Many committee members will be familiar with that fact, and I suspect that familiarity has prevented us from realising the real and immediate challenges that we face. Undoubtedly, the core measures that we are reflecting on today have helped significantly to make residents of care homes and individuals who receive care and support in their own homes much safer. However, having gone through the past 20 months, we are seeing evidence of real and profound impacts on the sector, not just because of the measures but because of the pandemic as a whole.

Those impacts are in three areas, one of which is workforce. During the first wave of the pandemic, workforce stability was in the high 80s in percentage. Very few people left the sector. They were dedicated, they stayed and they were sacrificial in their working. Now, however, we are facing the biggest workforce crisis that social care has ever experienced, and that is having a profound impact on the stability and sustainability of the sector.

The second factor relates to the sector's economic sustainability, which is of real concern. Social care is the fifth largest contributor to the Scottish economy as a whole, and Scotland has a unique small-business social care make-up. If we fail the sector with inadequate resourcing, and if more and more providers go to the wall—as we are seeing happen now and as we will see this winter—that raises profound questions about sustainability.

The last factor is a whole set of additional elements that have come in in the past few months. For example, insurance premiums for care homes are absolutely rocketing. In 2019, the average payment due was about £3,000 to £5,000. Last year that rose to £17,000. This year, for the same coverage, providers are being charged £30,000 by insurance companies. That makes a small, family-run business virtually impossible to sustain especially when added to the real challenges with energy cost increases, transport and all the consequences of the instability that is brought about by the wider workforce.

Those three factors are impacting on the sector today. Although the measures are keeping people safe, they are certainly not addressing those significant issues.

The Convener: Thank you for the challenging insights into all your sectors.

My question is probably for Donald Macaskill. During the pandemic, care home visiting was stopped to protect the most vulnerable. That was very difficult for all the families. However, following the petition that was lodged by the care home relatives Scotland group, the Scottish Government is planning to introduce legislation known as Anne's law, which will define a resident's right to see and spend time with those who are important to them. What are your views on the feasibility of balancing visiting in care homes with the need for infection prevention and control measures?

Dr Macaskill: Scottish Care supports the broad principles of an individual resident's having the right to have family, friends and others visit them. Clearly, the early public health measures to prevent visiting that were taken in Scotland were necessary, and they undoubtedly saved many lives. Unfortunately, as we all know, the fact that those measures remained in place for longer than was perhaps necessary has resulted in real

psychological and emotional deterioration—and loss of life, undoubtedly—on the part of residents, and it has had a negative impact on the whole care home community.

As we move forward, we need first and foremost to remember that our primary duty is the preservation of life—a life that is lived to its fullness; not just keeping people alive, but keeping them living as they would want to live. The challenge for us in the future is that an infectious disease still exists and might increase its robustness in the community. We know that harm comes to an individual resident from the outside community, so we will all be required to work together to balance the rights of an individual to see family and friends with the rights of other residents and the rights of staff to be protected and kept safe from harm.

We are in a very different position from where we were this time last year, for example. The majority of care homes are now trying to be as flexible as possible, even during an infectious outbreak, if it is appropriately managed. We will move forward to try to restore ourselves to the situation that existed before the pandemic, in which I could count on a couple of hands the number of instances of disagreement about visiting.

However, as we move into winter, the threat of community transmission increases, as does the challenge in our care home community. Last week, sadly, we lost 10 residents in our care homes as a result of Covid. That is significantly better than where we have been but, even with all the protective measures such as vaccination, personal protective equipment and social distancing, we are still losing individuals. We must never take our eyes off that real challenge in the months ahead.

The Convener: Thank you very much for that. I put my next question to Donald Morrison. To give a bit of background, it is a case that I have been made aware of in the past 24 hours. Back in September, a lady was diagnosed with a tooth abscess and a related infection. Her dentist prescribed antibiotics and said that she needed to have root canal surgery. However, due to Scottish Government restrictions, she was not able to get an appointment for that surgery until April 2022, so she continues to be in a lot of pain. What is your response to claims that private patients are being prioritised at the expense of NHS patients? Are those true?

Donald Morrison: I am sorry to hear about that lady. The big issue on that particular question, at a local level and certainly in my practice, is that nobody is left in pain. There are facilities in practices for pain relief measures for patients that can be taken without even having finished a definitive surgery.

We believe that the system allows us to treat such patients, and I urge any individual patient who is in that situation to contact their local health board and dentist, and to communicate with them, because communication is one of the big problems. We find that dentists do not always know exactly what they are supposed to do in such a situation.

Quite a few such patients were not registered with a dentist prior to the pandemic, and there is no incentive—and there was certainly no facility during the pandemic—for a dentist to take on a new patient who was in that situation.

09:45

The private sector in dentistry is a separate question. It is slightly more complicated, in that each dental practice exists as an individual entity. We are, in essence, private contractors who work for the NHS. There are probably around 1,000, perhaps 1,100, dental practices in Scotland, but only a handful, perhaps 30, are completely private. The rest do a combination of NHS and private work. We call them mixed practices and they do a bit of both.

Prior to the pandemic, a small proportion of a dental practice's work might be carried out privately, which would help to subsidise the practice. Each business has to function, just as a hospital or care home has to function. It just so happens that the work is mixed in the one building. When that private revenue was cut off, there was only the NHS support, and those practices became almost unviable.

To build strength back into the sector, we need to continue working in a mixed fashion to allow those practices to run or they will fail. There has been a funding package, which has helped the dentists, but we would say that there are winners and losers. Certain practices have had larger payments and are doing better, while others are now doing worse, and we are trying to work our way through that.

The problem with individual cases is that they get a bit mixed up with the fact that there will always be people who feel that they cannot be seen in the way that they want to be seen. I urge those people to contact any dentist in their area. All dentists are working really hard to deal with the situation for those patients—nobody wants to see anybody in pain.

As far as dentistry is concerned, the private sector has supported and buoyed up the NHS sector for a long time. That is not well recognised. Unfortunately, as we come through the pandemic,

we do not know what will happen because of the level of communication with the Scottish Government; we do not really know how things will go. Will we return to the treadmill of the broken system that was being reformed prior to the pandemic? The clinicians are not aware of how they are supposed to proceed, but under all circumstances they must make their practices viable for their patients. There will always be people who fall through the gaps, but on a personal level I can only reassure you that the situation you raised would not happen on the watch of 90 per cent of dentists. We are working very hard.

In medicine, there will always be a system where people pay privately to have something done faster, for better materials to be used or to do X, Y and Z. In some cases, patients will refuse to have a tooth removed. That is a viable treatment option to remove infection and make the patient well, but that will not be what they want. Therefore, it sometimes takes time to treat that patient. I am sorry to hear about the case that you mentioned, but as far as the BDA is concerned I am sure that any number of clinicians in that area would take a call from the patient and see them.

The Convener: Thank you for that guidance. I am sure that all elected members have such issues in their inboxes at the moment, because of this very challenging time.

During the past 18 or 19 months, it would have been irresponsible if we were not putting measures in place to stop the challenging situation, and we all know that we are facing a challenging winter. However, on Tuesday 9 November, 2,233 new cases of Covid-19 were reported in Scotland and yesterday that number rose to 3,852 new cases, which is very alarming. Do the three of you believe that the vaccination passports should be extended to other settings?

Dr Buist: I would support that. If I go into a cinema or theatre, it would be useful to know that people who I do not know have been vaccinated. That would give me some comfort.

Dr Macaskill: Having said that the relationship between community transmission and what happens in a care home or somebody's own home is now undeniable, I would be in favour of extending the use of vaccination passports. However, we must be extremely careful that we do not think of them as a panacea to address the rising number of cases.

When I wander around Ayrshire, where I live, I am equally concerned about the increasing evidence of people being lax in wearing masks. Thankfully, Scotland has a policy to encourage mask wearing in public spaces, but we need to think about toughening our stance and removing the abuses of that important protective measure. Unfortunately, because of Covid and the increase in respiratory conditions such as flu and norovirus, I have absolutely no doubt that we are likely to see increased restrictions and I hope that they are introduced early enough to be sufficiently protective.

Donald Morrison: The big thing in the dental sector is that the other baseline measures that we use—social distancing and mask wearing—just go out of the window as far as dealing with our patients is concerned because a dentist cannot socially distance when treating a patient, and the patient cannot wear a mask.

We would not necessarily be against the extension of vaccination passports. We would be supportive of it, but I would be wary of creating a situation in which patients did not seek treatment without a vaccination passport. We would worry most about patients who have benign or asymptomatic oral cancer and who we have not seen for a couple of years. They can be picked up early. If we just lay our eyes on them and see the cancer in their mouths, we can send them on to the right place. That is a huge thing. Picking it up early saves a huge amount of money, effort and time for the patients and hospitals.

I would be concerned about a passport stopping such patients from seeking treatment. We are talking about older male patients—smokers and drinkers—who would use the requirements to avoid seeking treatment. That said, we should carry out a proper education programme and educate patients that, as opposed to having a vaccination passport, whether they are vaccinated could form part of their clinical records.

We generally assume that patients have Covid and treat them accordingly. We socially distance where we can, and we wear our own PPE. It is difficult working in FFP3 and respirator masks. It is exhausting and the profession is exhausted by it.

Extending the vaccination passport would not make a difference for us in treating patients. We are not against it but we worry that it would become a barrier to treatment for some people.

Murdo Fraser (Mid Scotland and Fife) (Con): Good morning. I have one question for each of the witnesses. I will start with Donald Morrison.

My question is a follow-up to one of the convener's questions. She relayed an experience of a constituent of hers. A number of constituents have raised other issues with me, but there is a bit of a theme here. Constituents are saying that private patients have access to treatments that are not available to NHS patients, and that has led to some of them becoming private patients, if they are in the fortunate position where they can afford to pay. There is, of course, a danger of creating a

two-tier system. Will you explain to us why it is that a private patient can get access to appointments and treatments that NHS patients cannot access?

Donald Morrison: I go back to my previous answer. Each individual practice is essentially set up as a microhospital. During the course of the pandemic, the clinicians who run practices need to make them viable. The private part of their income subsidises and supports the practice. Without that, they cannot and will not exist.

There is no doubt that there are large NHS practices that are running at over 100 per cent compared with previous measurements. They have to go that quickly to generate the income to get resources into the practice. That might sound a bit strange but, to explain it, the percentage that is paid through the Covid recovery or support payments is 85 per cent of what the gross amount to the practice would have been—what the building would have brought in. In order to make that work, generating a larger income from private treatment is not about the patient being private; it is about the treatment being carried out in a different way, using different materials or taking more time, and so on.

The provision for the NHS, as stipulated by the NHS recovery plan, is that clinicians have to work—and they do work—in the NHS sector and to provide as much as they possibly can. At the moment, we receive support by way of PPE to treat up to 10 patients a day. A practice that used to see 40, 50 or 60 patients a day on the NHS will be receiving the resources to treat only 10 patients a day, with increased time between patients and fallow time.

Dentistry is unique in that, while being in a patient's mouth puts clinicians at high risk of catching Covid and other respiratory diseases, we also produce an aerosol in most things that we do, which disperses infection into the air. Fallow time means that we wait for a period after doing surgery in a room that does not have adequate ventilation. That fallow time can be anything up to an hour before people can go back into the room.

There are situations where it is possible to increase ventilation, and we are working hard to do that so as to get the fallow time down to 10 minutes, using high-speed suction. However, the process of doing that, together with essentially the same remuneration of the practice, means that dental practices must do more work privately to generate the same income as before in order to make their businesses viable.

If we can only see 50 per cent of the patients that we could see before, there will inevitably be some patients who report to you their perception that they could not be seen. That does not mean that they could not be seen, but there will be waiting lists. The waiting lists might be four, five or six months. No practice and no clinician will leave a patient in pain, however—that will not happen. Our members are very careful about that.

I have done this in my own practice. I have had an NHS practice along the road saying that it cannot see a patient, and we have taken them and seen them on the NHS, helping them out and passing them back. We work together, as clinicians. There will always be some outliers: I have no doubt that there will be some situations where patients will need to fit in. We still get people who say, "I can't come because I'm working" or "I can't do this" or "I can't do that," but we must recognise—going back to my previous answer—that, if there is a problem and a patient needs to be seen, they will be seen on the NHS. As for whether or not the treatment is carried out immediately, we are still in a backlog. Having lost 4 million appointments and working at 50 or 60 per cent, by definition we cannot be back to where we were. It is certainly not business as usual. Pain relief and pain management can be done, however.

Some dentists and other clinicians in the private sector have invested in huge amounts of ventilation systems and bought their own PPE in order to work as well as they can. Patients go to those clinicians and pay privately to have the work done; that is the same in any medical sector and has been so for a long time.

10:00

Murdo Fraser: Thank you, Mr Morrison; that is helpful.

I have a slightly different question for Donald Macaskill. When you talked earlier about issues in the care sector, you specifically referenced workforce issues. I have spoken to people in the care sector who say that one of the major issues has been the number of experienced and qualified staff who are leaving the care sector to get jobs in other sectors, such as retail, because the pay and conditions are better. I am interested to understand from you how much of an issue that is. If it is an issue, what needs to be done to fix it? How do we ensure that pay and conditions in the care sector improve and that people do not leave to get jobs elsewhere?

Dr Macaskill: You are undoubtedly right that it is the most significant issue that faces the care sector, because we are haemorrhaging experienced, skilled staff—nurses and carers—who are going elsewhere. There has been a step forward with the Scottish Government announcement of an increase in the carers salary to £10.02 per hour, which takes it above the living wage. That is only the first step in a long journey

towards a destination of parity with the NHS, in particular.

We carried out a survey with our members over the summer, which was published in September and showed that nine out of 10 members are struggling to recruit. The responses showed that 40 per cent of people who are called to interview do not turn up, and that 60 per cent of people who are appointed leave within the first six months. Care is a human, engaging and valuable piece of work, but it is not a career for everybody.

The response to the question of what we need to do is multifold. We need to increase baseline salaries, because £10.02 per hour is good and better than it has been, but the same individual can get a job in retail or hospitality for more money. I am not dissing those environments, because they are extremely important to our society, but they do not require an individual to be registered, regulated or qualified—all for £10.02, which is simply not sufficient. I like to think that the way in which we reward people who care says something about the nature of our society; at the moment, Scotland is failing in that relationship.

However, there are other factors. At the moment, the NHS and local authority partnerships are engaged in a massive recruitment drive. In the past week, a rural care home in Forth Valley reported to me that it has lost three nurses and four carers, all of whom have gone to the NHS in the local area. A care provider in Edinburgh has lost 15 per cent of his home care staff, because they have gone to work with the local authority. We do not want to stop people from moving on, but if we pay the same amount of money to somebody who is a domestic member of staff in the NHS as we do to somebody who delivers professional, skilled care and is qualified and regulated, that lack of parity means that, no matter how much we give to the social care system, we will always bleed our talent and skills elsewhere.

Undoubtedly, another factor is that the retail and hospitality sectors are dramatically short of staff—in no small measure as a result of their inability to recruit internationally. Therefore, particularly in rural parts of Scotland, our members are saying to us that they are losing care staff to secure, less stressful environments that are not able to recruit internationally.

There are many steps that we can take. Take home care as an example: we still have home care staff doing 15-minute visits, seven minutes of which is taken up donning and doffing their PPE safely. They will be penalised—their organisation will be penalised—by electronic call monitoring systems that were established by the local authority. The way that we are treating our front-line care workers is appalling and abysmal. Yes, we clapped on a Thursday for several months, but solidarity needs to be seen, not by forgetting the care workforce but by resourcing them, skilling them with adequate training and giving them access to all that they need.

Murdo Fraser: Thank you, Dr Macaskill. You talk about the increase in the base salary to £10.02. Do you have a sense of what level it should be at in order to ensure that we do not face the issue that you have been talking about of staff haemorrhaging out of the sector?

Dr Macaskill: At the very least, we need to create parity with the NHS. Under the national care home contract, which is the deal between the independent sector and the state, a care home manager, with all that responsibility, is paid £13.50 an hour, when a carer is paid £10.02. We are having real problems with recruiting and holding on to senior staff because of the lack of differential. Trade unions have advocated a starting salary of £15 an hour. Ultimately, we need to move to a level of parity, but we need to take significant steps in the immediate future. I know that finance experts will say that the cupboard is bare. There is a very real risk of social care collapse this winter, unless we intervene with additional resource to retain staff—Unison has suggested retention payments to hold on to existing staff—and to provide a starting salary that properly recognises the amazing skilled job that caring is.

Murdo Fraser: Thank you, Dr Macaskill. Dr Buist, you have talked about challenges with surging demand on GPs as we go into the winter and the pressures as a result of the fact that we simply do not have enough GPs in Scotland to address the public demand. Clearly, we cannot produce a GP out of thin air. It takes, I think, six or seven years to train a GP. Is it the case that we are facing a legacy of issues that we should have addressed many years ago and that it is going to take a long time to catch up?

Dr Buist: When we entered the pandemic, we were not in a good situation—we were short of GPs. We were trying to address that through the 2018 Scottish general medical services contract. We wanted to make general practice more attractive and to encourage more young doctors to be GPs and older GPs to stay on a bit longer. We were trying to build up the multidisciplinary team—pharmacists, nurses, physiotherapists and mental health workers—around the practice to take away some of the work that GPs were doing that could be done as well or better by other healthcare workers. However, the pandemic struck, and we had not delivered on all those things.

Premises is another big area where we have a legacy of not investing in our infrastructure, and that, too, has caught us out during the pandemic. For example, social distancing and one-way

systems are difficult to manage in small waiting rooms, and there can be problems with ventilation. Therefore, we were not in a great situation before the pandemic, and it certainly found us coming up short.

Alex Rowley (Mid Scotland and Fife) (Lab): I want to start with Dr Buist. Many of these problems existed before last winter and before Covid. What should the Government be doing that it is not doing to prioritise in order to get through the winter?

Secondly, should we be looking at system change and, if so, should we be doing that now or should we wait and just put all our energy into getting through the winter? By "system change", I am referring to an article that the previous chief executive of NHS Scotland, Paul Gray, wrote in October in which he set out the need for system change, highlighting the primary care systems in Alaska and Sweden and saying that such systems can deliver. Where do we as politicians strike the balance, and what should the priorities be? Can we do both things?

Dr Buist: That is a very big question. As far as system change is concerned, we are in the middle of a pandemic, so that sort of thing will be difficult to do this winter. The Alaskan model is very resource intensive; if the Scottish Government wanted to move to it, we could certainly look at that. One of the biggest problems, though, is that we have not invested sufficiently in community health and social care.

I take you back to David Kerr's report of 2005, which ultimately concluded that we are not providing the healthcare system that our patients and the Scottish people need. There is far too much focus on acute care and hospitals and not enough focus on access to care in the community. The pandemic has absolutely exposed that situation.

It is just the nature of things in this country, as it is in many other countries: the focus is not on community care. It is the same with social care, as Donald Macaskill suggested earlier. We take many of these things for granted and the focus of the media, the public and the politicians is on what is happening in hospitals and accident and emergency departments when there should really be much more investment in and focus on the community. We could fix that right now while we are still in the middle of a pandemic, but I think that when we come to review and reflect on what happened in the pandemic, these are the sorts of issues that will need to be explored.

The workforce in the community is short of people, and I have already highlighted to Murdo Fraser the situation with the infrastructure and with premises. Ninety per cent of GP premises are more than 10 years old—indeed, some are more than 50 years old—and they are not really fit for purpose. We spend very little NHS capital on community buildings; instead, that money tends to get put into developing hospital facilities.

In short, we are still in the pandemic, and we need to learn lessons in order to move forward—and not just in case we have another pandemic. The issue is what is most important to the people of Scotland.

Alex Rowley: Mr Macaskill mentioned the relationship involving private home care providers. I suppose that you could say that it is contract based; indeed, it is very much seen as an internal market. Is that part of the problem? When I talk to home care workers, they tell me about their 15-minute visits and having to be on and off the clock. Is there a real disparity between local authorities' treatment of their own workers who provide care and of those who are employed by the third sector or a private provider? If so, should we start by looking at where best practice is and trying to go towards it?

10:15

Dr Macaskill: Yes, there is certainly a disparity, and it has hypocrisy at its heart. To take home care as an example, the electronic monitoring systems that are used on staff in the third and independent sectors are very rarely used on staff who are employed by a local authority. This week, one local authority is advertising jobs for home care staff at £14 an hour, which is more than a care home manager gets in the third or independent sector. There is significant disparity.

Last week, two independent studies evidenced that a reasonable cost of delivering 24/7 nursing care home provision would be between £1,000 and £1,200 a week. Under the national care home contract, the state pays only £750 for a state-funded person in a care home. There is a huge gap. The average local authority care home cost is closer to £1,300.

Yes, there is a gap, which, unfortunately, those who are self-funders in care homes and those who are, increasingly, funding their own care in the community are having to match. That is unfair and inequitable, especially for women and men who are unfortunate enough to develop dementia and who, in the later stages of their illness, will have no choice but to receive 24/7 specialist care in a care home. Were they to have, unfortunately, developed cancer, all the care and treatment that is delivered substantially through the NHS and community, primary and secondary services would have been paid for them. Inequity goes through our health and care system like letters in a stick of rock. The situation is dependent on the condition

and on who delivers that care. However, at the end of the day, Mr Rowley, the worker—the carer—gives the same compassion, even if she is not rewarded or recognised in the same way.

Alex Rowley: My next question is for Dr Buist as well. In guidance that was published last week—I think NHS Tayside was highlighted as an example of good practice—it was suggested that people who approach accident and emergency be referred to wherever they should have gone. I saw that Dr Buist commented on that. The guidance suggests that such people will be referred back to the community, but we seem to have a crisis in the community. People contact me daily to tell me of the difficulty that they have had in securing appointments with a GP or a medical practice. There are growing waiting lists of people who have been assessed as needing social care—home care—in the community.

First, does that pour pressure on to accident and emergency departments, which is where people will eventually turn up? Secondly, is it acceptable that accident and emergency departments can refer people back to the community setting, despite that setting being unable to cope?

We will start with Dr Buist.

Dr Buist: I am happy to take that question. I support the principle of redirection as it has operated in Tayside for more than 10 years. Broadly, the Tayside public know that if they have a non-A and E problem, they should not go there. If, for example, they have had back pain for two months, A and E is not appropriate; the decision maker will redirect them.

In July last year, I suggested that to Jeane Freeman as a better model for addressing the four-hour waits than the redesign of urgent care, which I do not support. As a model, it needs to be well communicated and understood by the public, and introduced gently. As you have pointed out, places are needed for those patients to go to. That might be the community pharmacy—which is an increasingly useful model—or the general practitioner. As I mentioned earlier, general practices in Scotland often see more than 500,000 appointments every week; that is one person in every 10 in Scotland having a clinical consultation at their general practice each week. However, our capacity is finite and at some point—very often, just now—it is exhausted.

I go back to my earlier point: we do not invest sufficiently in our community healthcare capacity. Right now, we are short of general practitioners, practice nurses and pharmacists and physiotherapists working in general practice. We must continue to deliver the new GP contract, which is about increasing the number of GPs and multidisciplinary team members attached to practices to meet that demand, so that patients do not have to go to A and E when it is not appropriate to do so.

Dr Macaskill: I agree with Andrew Buist. As the committee will know, if somebody cannot be supported in the community, because home care services do not have workers who are able to do the job, those care packages are handed back or they cannot start. That puts huge pressure on our colleagues in community nursing and general practice. At the other end, if somebody is ready to be discharged from hospital, but care homes or home care services do not have staff or capacity, the whole system is blocked.

At the moment, it can sometimes feel as if we have a 25-year-old car that we have decided to spray-paint, while ignoring the fact that the engine has broken down. We have to start working as a whole system. Unfortunately, the way in which we prioritise attention to secondary care—acute care, in particular—means that social care and, to some extent, primary care are left on the sidelines.

We need to start talking. We have not had a strategic national gathering of individuals in the sectors of social care and health for a considerable time. Social care partnerships and providers from the public sector might be talking to health colleagues, but I know for certain that people like me and my colleagues in the third sector, who deliver 70 per cent of social care in Scotland, are simply not at the table at the moment. That means that there is a failure to learn from the pandemic and to be present in terms of the pandemic response.

Alex Rowley: When I have raised issues with NHS Fife around social care, the chief executive has been quick to tell me that I need to speak to the chief executive of Fife Council, who is equally quick to refer me to staff three or four levels down the system and tell me that they will get back to me. Nobody seems to be taking responsibility. Are the health and social care partnerships and integration joint boards fit for purpose, and do they have the capacity to meet the challenges that we will face over the coming months?

Dr Macaskill: That is a huge question. The consultation on the national care service is, in part, about redesigning the system of governance around health and social care. The primary point at the moment, if we are to get through the very challenging winter, which has now started, is that the whole system at both local and, increasingly, national level needs to start including the third and independent sectors. There is tremendous partnership working in some parts of Scotland, but in other parts the NHS tail is wagging the social care dog.

Brian Whittle (South Scotland) (Con): Good morning. I will start with a very general question. I always think that, if we are to have a working healthcare sector, we need to look at the morale and health of the professionals in the sector. What is the situation in that respect compared to what it was pre-pandemic?

Donald Morrison: To describe morale as low would be a huge understatement. The profession is struggling under the cosh of the pandemic, but prior to that, it had already been recognised that our system was not fit for purpose. We were in the process of trying to reinvigorate and reinvent dentistry, but we have now been told that that process is not going to be addressed any further, because, as the health minister has said, making any large changes to resolve or reform the system would be a problem. I go back to Mr Macaskill's analogy of the 25-year-old car getting a respray: we have a 60-year-old car that was due a respray but which is now not getting even that.

In a recent poll of practitioners, 80 per cent suggested that they would be reducing their NHS commitment, and 30 per cent of those said that they would be looking to retire early and leave the system. The morale of clinicians is low, and it is particularly low among staff. We are hearing stories of practitioners who are having three or four staff members in what are small practices turning round to them and saying, "It's time to move on." They can get jobs in hospitals, Tesco and so on and not only get paid more but reduce the problems of having to work with PPE and, indeed, FFP3, where they have to wear a respirator mask for large quantities of time. We are losing nurses and dentists, and there does not seem to be much in place to bring anything back in.

Morale is particularly low just now. To be honest, I cannot really say any more about that.

Dr Buist: Morale in general practice is down. The people who work there are tired—I am certainly tired. As well as talking to you guys, I work two days a week in general practice, and we have been on the front line of this pandemic since March last year. Things have been unrelenting and are constantly changing. We had the early phase, the shielding and then the problems of longer waiting lists in secondary care for out-patient operations, which cause back pressures for general practice. We have had rising levels of mental health issues such as stress, anxiety and depression among our patients, and those problems very much land on general practice.

There has also been the awareness that demand has outstripped our capacity, despite our valiant efforts, and the criticism that has been unfairly levelled at general practice by certain sections of the media and certain politicians has been very demoralising when you are absolutely doing your best. In some cases, that has, unfortunately, led to patients verbally abusing practice staff; indeed, 88 per cent of practices have reported that they were aware of incidents of verbal abuse in the previous month.

We are not in a good place just now, and I worry about workforce retention. Indeed, I know many GPs who are looking at whether they will stay in the profession or reduce their time commitment, just for their own personal wellbeing. As I have said, we are not in a good place as we face what has been acknowledged to be a most difficult winter.

10:30

Dr Macaskill: Morale in social care has just gone through the floor. Similar to what Dr Buist said, social care workers were on the front line, have been on the front line and are still on the front line, and they are absolutely exhausted. They are running on empty. People have kept going through all the physical and emotional challenges because they felt that it was their obligation and responsibility to those whom they support and their colleagues. Part of that ability to keep going was a sense of value, but, as time has gone on, that value has diminished and been depleted.

The obscenity that is operation koper has resulted directly in numerous staff leaving the sector. We all want answers to the loss of lives, but the victimisation and disproportionate use of power by the Crown Office is shameful, and it shames our nation. We must draw a line under that. We have people who, 20 months after their initial interview and the evidence gathering for people who died in care homes, still do not know what is going to happen with that information. The care sector—our care workforce in the community and in care homes—is feeling hugely demoralised, physically and emotionally.

I had the privilege of chairing Scotland's working group on our national bereavement charter. The impact of grief and loss on those in the social care sector has been hugely significant during the pandemic. It is now becoming an issue of very real concern. Individuals are experiencing what, clinically, is described as prolonged grief syndrome. It is a trauma that they have experienced, which has led people to leave the sector and which I am absolutely sure will lead more people to leave. You address that trauma with appropriate mental health support, but you also significantly address it by making a woman or a man, a nurse or a carer feel valued, respected, wanted and appreciated. Unfortunately, the whole of our society has singularly failed to do that for front-line social care.

Brian Whittle: I thank the witnesses for their answers. It is certainly a concern. I have always thought that the first step should be to look after the health and wellbeing of those who look after us.

Mr Morrison, you described a system that was creaking and not working pre-pandemic, and you are suggesting that it is now down at about half its capacity. Can you catch up while the Covid measures are in place? First and foremost, do we have to accept that, under the current conditions, it will be nigh on impossible to catch back up to where we were pre-pandemic? What needs to happen to return to a balanced operating system? Linked to that, is there an opportunity to reassess and redesign the system on the basis of learning from Covid?

Donald Morrison: In answer to your first question, no. As things stand, I do not think that we can catch up. Recently, we have been told by the CDO and the Scottish Government that we will return to the previous remuneration method—the statement of dental remuneration, or SDR. That is a fee-per-item process, which pays the clinician or the practice for the treatment that they carry out on patients. It is a really old system. As I said, it has been around since the 1950s. It is based on getting patients in fast—doing any treatment that they need as quickly as possible and getting them out the door. It is not nice for patients, and it is a really difficult system to work under. We refer to it as the NHS treadmill. Before Covid, at the end of 2018-19, we started to talk about the oral health improvement review and we were looking at possibilities. The negotiations were perhaps not going very well, but at least it was being acknowledged that we need to take more time and to concentrate on prevention.

I acknowledge the support that the NHS sector has had from Government under the system that we have had in place throughout the pandemic. For those dentists who have continued to work, the maintenance package has kept them afloat. However, we have been advised that it will be taken away from us in April next year, and we are supposed to have time before then to enable us to keep things right. However, if we are only going at pace, we will not be able to address the issues, and certainly not the backlog, and once the package is gone, we will be going at half the pace from then on. If we are to deal with the backlog in a realistic way, the answer to the question whether we can catch up while Covid measures are in place is, quite simply, no.

It would help if more dentists could be provided, as there are currently fewer dentists being educated and trained. We used to benefit from a lot of dentists coming from overseas, but Brexit has meant that those coming from Europe are much fewer in number, so we are suffering now. Addressing that would be a positive move.

As far as baseline measures are concerned, mitigation in general practice is difficult. When we go into the profession, we know—certainly I have always expected—that we will be exposed to a lot of respiratory viruses; that is the nature of working in a person's mouth and being close to them. However, we are waiting for the infection prevention and control guidance that was reviewed last year and has still not been published down to professionals in Scotland. We do not know what we will have to do under that guidance.

We currently keep patients in waiting rooms outside, and where waiting rooms are small, we keep them waiting in cars. We escort them on and off the premises and do hand-washing and hygiene procedures. That all takes a colossal amount of time. There is also a need for fallow time, as I mentioned earlier. When we are working with a patient, we need to allow time for the droplets to fall before cleaning the area. We have looked at different options to deal with that, but at present we are draping the place in plastic.

We have ventilation—we are trying to get 10 air changes per hour in the room, and to get the fallow time down. However, that process drags all the warm air out of the building, so our heating costs are increased. One minute nurses are working in PPE, wrapped in plastic, and the next minute they are freezing cold because we cannot heat the room on the other side. God knows what we are doing to the environment. Trying to keep those mitigations in place to protect people from Covid is, ultimately, causing a lot of problems in other parts of the sector.

The process for helping with ventilation could be effectively increased. We have had Government funding to the tune of £5 million to help with measures in practices, but that works out at about £1,500 per surgery, and I have yet to find anyone who can put in effective ventilation for that amount. A lot of practices are in old buildings. I have colleagues who have put in adequate ventilation that has cost to the tune of £15,000 or £20,000.

Although those measures need to be in place now to make the environment safer for clinicians and nurses, we have been pushing for a redesign of the system since before the pandemic—almost for as long as I have been in dentistry, which is over 20 years. A redesign is really important, but we have been advised that, at this point, it would be a poor move and that the Scottish Government wants us to get back to our backlog. If that is not going to happen, however, we need some sort of redesign. The system needs to keep the support payments to practices in place if the NHS sector is to be kept alive, otherwise it will be lost.

Of all the issues that I have mentioned, the biggest and most important is a huge lack of communication. I obviously hear some things earlier through my contacts in the British Dental Association, but my colleagues hear things through social media. There has been absolutely no consultation on many of the decisions that have been made in the past 18 months.

We all accept that we are in a situation that is almost untenable, and we are working hard on it together. If there were better communication, we would feel as though we were working with the Government, instead of feeling as though the Government is against us. We are constantly asked why we are not getting on with things and told that it should be business as usual. It just is not business as usual. That message is put out in the press and into the public domain—by politicians, I suppose, but the media have not helped. We are seen as the bad guys when we are working desperately hard not to be.

We need assistance with ventilation and an acknowledgement of the situation. There is one idea that might be quite unpopular, so I will say that it is not BDA's position. Dentistry is a two-tier service. No one really wants it to be like that—if their work were properly recognised, dentists would love to do it within the NHS—but a two-tier service could be the way to clear the backlog of pain and problems. Pain relief, tooth removal, abscesses and a lot of the horrible things in people's mouths could be helped with a base level service. I wonder whether we could find a way to do that more efficiently, carefully and quickly for our patients, because the next two to three years will be very difficult. I suspect, however, that that might be an unpopular idea.

Catch up, no. Redesign, yes.

Brian Whittle: Dr Buist, we know that we were short of some 860 GPs before the pandemic. We were working towards having multidisciplinary teams and more community care. A lot of that was put on hold because of the pandemic. However, the pandemic resulted in a rapid deployment of technology. As we recover from the crisis, will the continued deployment of technology help doctors with the backlog and the development of future policy?

Dr Buist: Before I answer that question, I will comment on the previous one in support of what Donald Macaskill said. I am here to speak on behalf of general practice, but one of the clearest messages that we need to hear from the Scottish Parliament is that social care is the top priority that must be resolved this winter. I attended the Health, Social Care and Sport Committee meeting on Tuesday, where that was the outstanding issue. We must do something to support the social care workforce or else the pressure that that creates on the rest of the system will take down anything else that we try to do. That is one of the top messages that we should take from here.

Regarding whether technology might help us to catch up, in general practice we deal with today's work today. A wait of a week to see a GP is a long time. We do not have six or 12-month waiting lists to see GPs. We try to deal with problems now.

The area that has suffered most during the pandemic is the management of chronic diseases such as diabetes and heart disease where there is a need to manage health or to adjust blood pressures or blood sugar. We have not been able to provide as much support as we usually would in that area.

I thought you might ask me about the use of technology in consulting. Before the pandemic, we were already being encouraged to move to video or telephone consulting and we were particularly encouraged to do that when the pandemic struck, because of its benefits for infection control. I think that we will continue with a hybrid model of consulting. We will consult patients face to face, in person, when it is appropriate to do so but, when a problem can be managed by telephone, many patients appreciate having it dealt with quickly.

10:45

They might be at work or away from home, so it saves them time. It is efficient for the service and it is environmentally friendly, so technology for remote consulting is here to stay. With regard to technology for other methods of remote monitoring, we need to get the basics right before we adopt a lot of the ideas that are bubbling around and, right now, the basics are not right. Telephone consulting is fine, video consulting is coming in and other methods could come in, but we need to get our basics sorted before we move on to adopt large-scale technology.

The Convener: I am conscious of time; we have 14 minutes until the two-minute silence at 11 o'clock and we still have two members to go to, so we move to questions from John Mason.

John Mason (Glasgow Shettleston) (SNP): Thank you, convener. I am disappointed that some members have had considerably longer to ask questions than some of the rest of us. Mr Whittle has just had 22 minutes, but Jim Fairlie and I now have to share nine minutes between us.

I am also a member of the Finance and Public Administration Committee, which has been discussing preventative spending for some time. That work has been going on for some years, and this is the 10th anniversary of the Christie commission. The point has already been made this morning, especially by Dr Buist, that there has

perhaps been a concentration on hospital buildings rather than on those for the primary care sector, where all three witnesses work. Do you have any suggestions on how we take that forward? Assuming that there will be no extra money in total, should we trim money off hospital budgets and put more into primary care? That question goes first to Dr Buist.

Dr Buist: Thank you for that question. Yes, we should. The Government recently announced a £30 billion programme of investment in health service buildings and a 10-year plan to deliver it. I have said to Humza Yousaf that general practice and primary care need to get their fair share of that. The money tends to be devolved to the health boards for them to decide how to spend it, and they spend a vanishingly small amount on general practice and, I suspect, on community dental services. We need a fair share of that investment. As I said earlier, more than 90 per cent of the 1,000-odd general practice buildings across Scotland are more than 10 years old. In many cases, the pandemic has found them severely wanting in their ability to manage patients safely in large numbers, due to cramped conditions, inadequate ventilation and waiting areas being too small. There is an absolutely desperate need, and one of our top priorities is for the community to get a fair share of that investment.

John Mason: Could we also have the dental angle?

Donald Morrison: It is a difficult question to answer, because we are not necessarily privy to the numbers that are kept for health boards. Off the top of my head, the Scottish spend on dentistry is about £400 million, and £75 million of that comes from patient charges that the practices bring in. Almost all of those practices are, with few exceptions, in buildings that are privately owned by the practice. The system is so backed by the private sector working as independent contractors that it would be very difficult to do what you have suggested. I do not think that taking budgets away from hospitals to give to dentistry would be the way in which I would do this, but then I do not know about the budgeting side of things. I would have to pass that to the other witnesses, because I cannot really answer that question.

John Mason: Given the time, I will ask just one more question, which is on vaccination passports. For staff in certain settings—those working for certain care home companies, I believe—vaccination is being made compulsory. Is that the right way to go?

Dr Macaskill: Our stance as a national organisation is that we need to convince and persuade staff, answer their questions and give them assurance. The figures in Scotland are astonishingly high for the first and second doses of vaccination, but we will want to continue to address the sort of anti-vaccination messaging that has become fairly dominant in social media. That said, I do not think that that is an issue in Scotland at the moment, and I would like to hope that, as we move forward, we are able to build confidence in the workforce. I am very aware that, in the past 24 hours, colleagues in England have been talking about losing 50,000 care staff—and potentially 120,000 staff, with the extension of the requirement for vaccination into the NHS—but this is not a step that we are contemplating at the moment either in workforce management or to give assurance to care home staff and residents.

John Mason: I will leave it at that, convener.

Jim Fairlie (Perthshire South and Kinross-shire) (SNP): I will, first, give the healthcare sector my personal thanks. Members of my family are currently using various aspects of the service or working in it.

The witnesses have given us a huge amount to think about today. I know that we have only four minutes left, but any one of us on the committee could have used up the full 85 minutes trying to get through the massive number of questions that we have.

I will not ask any wee, pointed questions. The biggest issue for me is the compulsory vaccination requirement that the NHS in England is bringing in. Would that sort of move be accepted in Scotland? I know that Dr Macaskill has just answered that question, but I wonder what Dr Buist and Mr Morrison feel about it.

Donald Morrison: As Dr Macaskill said, public messaging is really important in dealing with anti-vax views. We believe very strongly in the vaccination programme, but anything that is likely to cause staff to leave or stop working terrifies most clinicians. Indeed, most clinicians would say, “I’m not going to do anything that will affect my staffing at this moment in time.” We are quite happy to promote the vaccination programme and feel that it is very positive and important. I should add that there has been full uptake in my practice. I cannot overemphasise the importance of that, but nevertheless we do not support compulsory vaccination. That said, we have all been compulsorily vaccinated for hepatitis B for years and years now, and it has never been a problem, but I would be really concerned about anything that would affect the workforce just now.

Dr Buist: I endorse my colleagues’ comments. Education and persuasion are the best ways of encouraging staff members to take up vaccination and I would be seriously concerned about the impact of compulsory vaccination on the workforce, who, as we have already said, are very

vulnerable just now. We will see what happens in England, but we should think very carefully before instituting a similar requirement here.

Jim Fairlie: In the interests of time, I will leave it there, convener. There is no danger of our being able to get into anything substantive.

Once again, gentlemen, thank you for the service that we have received. I know that it has been a hellishly difficult time for all of you. That is not a platitude—I mean it quite sincerely.

The Convener: I thank the witnesses for their evidence and insights into the challenges that they are facing. If you would like to submit further evidence to the committee, please do so in writing; the clerks will be happy to liaise with you on that.

The committee's next meeting is on 18 November, when we will continue to take evidence on baseline health protection measures.

10:55

Meeting continued in private until 11:07.

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