OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 20 June 2023

The Scottish Parliament
Pàrlamaid na h-Alba

Session 6

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

22nd Meeting 2023, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (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)
Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Pauline Howie (Scottish Ambulance Service)
Jim Miller (NHS 24)
Sue Webber (Lothian) (Con) (Committee Substitute)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 20 June 2023

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 22nd meeting in 2023 of the Health, Social Care and Sport Committee. I have received apologies from Tess White, and Sue Webber is joining us as her substitute.

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

Members *indicated agreement.*

Scrutiny of NHS Boards (NHS 24 and the Scottish Ambulance Service)

09:00

The Convener: Under our second agenda item, we will continue our scrutiny of front-line national health service boards. I welcome to the meeting Jim Miller, who is the chief executive of NHS 24.

We will move straight to questions. What efficiencies do you envisage will provide the £2.9 million of savings that are required by the board?

Jim Miller (NHS 24): Good morning. Thank you for giving me the opportunity to speak on behalf of the organisation.

The efficiencies that are set each year as a combination of our annual efficiency target and any balancing figures are based predominantly on recurring and non-recurring items. Recurring items are, by definition, those that we are able to take out of the system year in, year out, and non-recurring items are those that give us movement within a year and might, therefore, be different from year to year.

The plan for our savings target of just under £3 million involves a mixture of recurring and non-recurring items. The majority of the £3 million will be covered by non-recurring items in year 1 as we continue to stabilise the organisation's position following the pandemic. Those efficiencies relate to procurement and services that are contracted in, particularly our technology services, and a significant amount relate to the on-going increase in our workforce and our ability to blend when we bring staff on board, which allows us to make efficiencies in-year. The board has signed off our annual accounts and is satisfied that we will make those efficiencies.

The Convener: That is helpful. How will you monitor your invest-to-save proposals? You have touched on them a little bit, and what you submitted to the committee in advance of today's meeting included some detail in that regard. You described them as "digital and workforce improvements". How will you ensure that they deliver the expected savings, and over what timeframe do you expect to see a return on that investment?

Jim Miller: First, it is important that we have a balance between investment and what I describe as continuing business-as-usual funding. The investment pot that we have set aside is designed to improve four or five areas. The first area, which is probably the most important one, relates to our workforce and our ability to recruit. We need to ensure that staff are effectively trained and, of

course, that they are retained, so that they stay with the organisation for as long as possible. Investments are being made in what we call onboarding—the way in which people access opportunities in NHS 24—so that we make it as easy as possible for people to join our organisation. That links to digital, which is the second area and perhaps the one in which there is most activity, given the shape of the organisation.

In relation to the return on investment, all our proposals follow a standard format. We ask what the efficiencies will be. We ask whether the proposals will be cash releasing or time releasing, whether they will improve system stability or whether they involve a completely new system replacing older systems in order to improve access. All investment proposals are judged accordingly against that type of checklist.

The Convener: That is helpful. How does the organisation balance the rising costs and vacancies with the plans for future expansion to meet the growing demand that we anticipate? There has certainly been growing demand for NHS 24 services over recent years, and projections suggest that demand will increase.

Jim Miller: We need to do things differently and more efficiently in parallel with one another. I think that the public recognise and trust the core service; that is borne out by the repeated and increasing demand. However, that needs to be blended with different ways of providing the service.

For example, at the end of last year, we introduced our first smartphone app. When introducing front-line digital technology, we need to be careful that that is seen not as a replacement for the services that people have become accustomed to and trust, but as something that augments those services. As a result of changes in demographics and our age profile, some patients and users of our services prefer to access them through a digital route rather than through a telephony route. We need to reflect that, but I believe that it is an and/and—we need to ensure that people have a choice in the way in which they access the service.

The Convener: Thank you. Sandesh Gulhane has a supplementary question on this theme.

Sandesh Gulhane (Glasgow) (Con): I will start by declaring my interest as a practising NHS general practitioner. More specifically, I have worked, and probably will work again, in a GP out-of-hours service.

I thank Jim Miller for coming and for the manner in which he has given us the data, which is much better than the manner in which a lot of other boards have given us information. My question is about the almost £800,000 underspend. You said that that underspend is due to your vacancies. Which group has been particularly impacted by that underspend?

Jim Miller: The organisation has grown significantly in the past two or three years. As you might be aware, the single biggest factor is probably our move from, in effect, an out-of-hours and weekend service to a truly 24/7 service. Investment was made in the redesign of urgent care and in the significant expansion of our mental health services through the mental health hub. In both those areas, very challenging recruitment targets were given. In all sectors, not least health, recruitment—particularly clinical recruitment—is a challenge. Therefore, a significant part of that underspend relates to our not being able to recruit as quickly as we would like to. I refer to my previous point about why it is important for us to invest in making that easier for people.

There is a relatively direct correlation between staff availability and access to services. I do not deny that, but that is why it is important that we look not just at increasing staffing availability but at increasing the number of alternative channels, such as digital ones, to make sure that any shortfall in one channel can be offset.

Sandesh Gulhane: I will expand my question about which group has been impacted. Is it harder to recruit in some areas than it is in others?

Jim Miller: I do not think that it is any surprise that it remains difficult to fill nursing posts. We offer a different environment for nursing colleagues—I think that it is quite a positive environment, but a lot of our colleagues who are in nursing posts do not recognise that, so we are working hard to make sure that they understand what the NHS 24 experience is. However, I am aware that we do not want to get into a position in which we are, in effect, robbing Peter to pay Paul by getting nurses from territorial health boards to join NHS 24 and, thus, leaving those boards with a challenge.

We are introducing blended roles, and our first test of that has been with NHS Tayside. Colleagues can work two or three days with NHS Tayside and two or three days with NHS 24, for example. That sounds relatively simple but, in the past, such arrangements have been a little bit problematic because they involve two contracts, two employers, potentially two sets of shift patterns and so on. We want to make that as easy as possible, and we believe that there is some mileage in allowing people to work for more than one organisation—an and/and rather than an either/or. That also makes it much more interesting for staff, because they get to widen their experience without having to make a single choice.

Paul Sweeney (Glasgow) (Lab): I thank Mr Miller for coming today. Information that was obtained by a freedom of information request shows that, in recent years, there has been an extreme increase in the number of dental calls to NHS 24. In 2018-19, there were 25,509 calls but, in 2022-23, there were 67,189 calls. Your submission explains that a new urgent care model that seeks to minimise onward referral is in place

"for all but dental and some pharmacy calls".

How has NHS 24 adapted to manage that increase in demand with regard to calls about dental complaints?

Jim Miller: All services have seen an increase in demand. During the pandemic, there were acute rises in demand for the services that were more difficult to access, particularly primary care services, including dental services. During that time, we were fortunate that a number of our dental colleagues joined us to enhance our core Scottish emergency dental service. We provided, for example, digital remote consultations through smartphones, if people were able to do that and were comfortable with it. That service was very useful during that time.

As public dentistry has opened back up, we have reverted to our normal model for the emergency dental service. It links into other out-of-hours services and the redesign of urgent care, but, predominantly, that is where there is access to public dentistry.

We continue to invest in all our services, including our dental service. We are balancing the demand to make sure that we offer the amount of access that does not create a challenge further down the line. I will try to describe that in a better way. In some cases, we receive calls because patients are finding it difficult to access other parts of the service. However, we get an equal number of cases in which people are looking for information or reassurance, so we can remove demand for the service. To answer your question about demand, I think that that is where we can do much more. As we enhance our digital resource, we can give people an increased level of comfort and more information so that they can make decisions to manage their own care.

Paul Sweeney: In the light of the reported difficulties in people accessing dentistry services and increasing numbers of NHS dentists removing themselves from NHS provision, have you noticed a structural change in access to dentistry since the pandemic? Would you consider further expansion of the urgent care pathway to help to meet the increase in the number of dental-related inquiries?

Jim Miller: I cannot say that I have noticed a structural change in access to primary care services as a whole. Some recovered at a different pace, and some demand profiles were different based on public perception of availability—I will not comment on whether that was real or perceived.

I go back to my original point. I believe that NHS 24 is in a fantastic position in relation to both upstream and downstream. In this case, upstream relates to there being involvement with the patient at as early a point as possible in order to provide them with information and advice that allows them to determine whether they need a dental service or whether they can manage whatever it is themselves at home.

Paul Sweeney: Thank you.

Sandesh Gulhane: I want to ask a few questions about performance as we look at the data that you have provided and information that we have received through FOI requests. Over the winter period, a large number of patients had to abandon their calls to NHS 24 due to long wait times. What analysis has been done on the effect of long waiting times on patient welfare?

Jim Miller: I wish that we had a system in which everyone got the information that they receive without the need to abandon. For me, every abandoned call is a learning opportunity. However, the analysis also shows that, although we use the phrase "abandoned", a proportion of those people received the information that they needed within what we call the interactive voice recognition—IVR—message that directs them as to whether they are in the right place, where they can find information online or whether they should contact another NHS service. A proportion of the people who do not stay on the call have received the information that they need.

Sandesh Gulhane: What is that proportion?

Jim Miller: I do not have that information to hand right now. Of course, it is not completely accurate, because, frankly, we do not know 100 per cent where people have gone after they have abandoned. However, we carry out fairly significant studies using third parties, asking people what happened next. I am happy to provide information to the committee on that at a later date. A proportion of those people say that they received the information that they needed, a proportion say that they will contact their GP and a significant proportion say they will call back at a later time.

09:15

We have to reflect that information in how we provide access to the services, and we are doing that in two ways. The first is by recognising repeat callers—people who have phoned back once, twice or, in some cases, five or six times, whose

call may have been answered more than once—and trying to understand their needs, to make sure that people can get the information they need with one call as opposed to two or three calls. The second is by finding out where else they have gone in the system—if I can use that description—and how we can better present our services so that they get the information at that point rather than creating a demand elsewhere in the service.

I will provide that information to the committee as requested. It is clearly a sample, but it is something that we do regularly.

Sandesh Gulhane: What is the vacancy rate for GPs who take calls during your busy periods?

Jim Miller: I am sorry, but I am not sure that I understand the question.

Sandesh Gulhane: I am asking about when GPs take out-of-hours calls for NHS 24. What vacancy percentages have you had during the months of November and December, when things get really busy?

Jim Miller: You are asking about vacancies in our out-of-hours GP colleagues.

Sandesh Gulhane: Yes.

Jim Miller: I am sorry, but I do not have that information. That would be held within the individual GP practices.

Sandesh Gulhane: I am sorry—I mean in the call centre where GPs go to take phone calls for NHS 24.

Jim Miller: Ah! Sorry—that was a misunderstanding. Clearly, we have what we regard as peak periods, and those tend to be out of hours, at weekends, on public holidays and so on. The vacancy rate changes all the time—I do not have a specific vacancy rate for a particular time—and that can be for a number of reasons. There can be a planned vacancy for annual leave or other services or there can be unplanned leave, which is for short-term sickness. The information that has been provided to the committee gives the overall absence rate for short-term and long-term sickness absence. It fluctuates from day to day, from shift to shift and from week to week, so I am not able to give you a specific answer.

Sandesh Gulhane: I think that the longest time for which people were waiting on a phone to get help and advice was over two hours. What do you feel you could have done differently, looking back at December last year, that you will take forward to this year’s December to try to avoid the same thing happening again?

Jim Miller: Last winter was an incredibly challenging time for all public services, including the NHS. I apologise for every wait that is longer than an individual requires. I think it is important to say, though, that our average wait times are still significantly lower than those extremes. Those extremes are unfortunate—I am not suggesting otherwise. However, there are a few things that we do. First, it is important to recognise that we never cut a caller off: there is no automated time whereby the system does that. The person will wait and they will be constantly reassured through updates on IVR about how long the likely wait times are. The IVR will also continually suggest that they can be directed to our online resources if that is appropriate.

Sandesh Gulhane: What is the learning that you have taken?

Jim Miller: Taking the examples of what we did during the winter, we can see how we can expand on those. For example, lots of our winter learning from information about the profiling over the peak periods was reflected in our Easter performance, and the performance over those four days was the best Easter performance in the organisation’s 21-year history. Some of the lessons taken were about managing our demand and capacity by making sure that we provide information and that the information that is digitally available is useful for people.

I also reference that, around December, we were experiencing very high call volumes related to people who were worried about Streptococcus A. That was a relatively short but intense period of demand that came about in a very short timescale, and there were lots of worried parents. We immediately had to present the information on that particular condition through our online resources. That was important in learning and understanding how quickly we can update and make topical the information that is available to patients.

Sandesh Gulhane: Thank you. My final question is about the future. You referenced how challenging and difficult the last winter period was, and my concern is that the one coming might be even worse, because we had a bit of a mild winter for a lot of respiratory diseases. Are you confident that we will see improved performance times and performance data compared to last time? What contingencies are you looking to put into place now to mitigate any other issues that might arise?

Jim Miller: Winter will always be the most challenging part of the year for the NHS, including NHS 24, and the situation is exacerbated when other services are not readily available. There are a few things that we have in place. The first is our continued focus on recruitment and retention. If we have more people available to provide the services, that will help incredibly. I am very pleased to say that we recently overachieved on one of our recruitment targets: we set a target of 200 and we managed to achieve just over 250 in the period, but there are still vacancies. As I

mentioned, we are looking at ways to improve on that.

Secondly, there have been changes to the system itself. One important change is the ability for people to understand where they are in the queue. There is a difference between someone having to keep the telephone to their ear for 30 or 45 minutes and their being offered the chance to keep their place in the queue but get a call-back when they are at the head of the queue. That means that they are able to go about their day-to-day business, which is more convenient for them, and we hope that there is less chance that they will give up and go elsewhere.

There is a challenge with that, though, and it is important to say that one of the reasons why we are cautious about it is that it can sometimes create unintended consequences. For example, if the caller is not there when they are phoned back, what do we do? How many times do we call them back? That resource is tied up in trying to contact a person rather than potentially answering the person who is next in line.

Those are subtle changes, but they can be really important.

The app has also proved tremendously interesting and useful for people. We were careful to provide a minimum viable product—basically a skeleton service—to begin with and then immediately get feedback from people on what they would like from it. We are on our third or fourth version now, and there is a healthy and continually increasing user group for the app. We are also now able to provide supplementary information—not just where the nearest access to the service is, but where the nearest complementary services are. For example, something that we are working on now, which will come out in the next few weeks, is where the nearest defibrillator is.

The last thing to mention on preparation for winter is the need to understand how the technology can provide answers to people without their necessarily having to speak to a member of our staff. We have embarked on a digital transformation programme that will take us towards the end of 2025, and we are already working on enhancements, particularly in mental health services, to make sure that people who have used us in the past can pre-populate their information as far as possible. That means that there is a shorter wait time when they start to speak to someone.

All of those things will make incremental improvements. I hope that, along with our internal planning, they mean that we are in as resilient a place as possible for the winter, whatever winter we may have.

Emma Harper (South Scotland) (SNP): Good morning. Thanks for coming today. You mentioned the IVR—the interactive voice response. People whose first or preferred language isnae English can phone up. Do you monitor how many calls are made by people whose first language isnae English or Scots? I am reading here that there is the ability to interpret Polish, Arabic, Mandarin, Spanish, Romanian, Süryani and Ukrainian. Do you monitor how many calls are made by people whose first language isnae English?

Jim Miller: We do, yes. Unfortunately, I do not have that data immediately to hand. We have seen a doubling of our translation service in the past 12 to 18 months, through our partner who provides that service. That has been not just a doubling of demand, but a change in the profile of the demand—you mentioned some of the languages involved—which reflects changes that are happening in the country. We have seen an increase in those calls, and we believe that it is a useful and important equality measure to make sure that people can access the service regardless of their choice of language.

Emma Harper: Sometimes, people might not be aware of it, so they might go to the emergency department instead of phoning 111, because they just assume they will not be able to communicate. If we make people more aware of the fact that there is this interpreting ability with 111, that is a good thing.

Jim Miller: Yes, absolutely. Later this month, we will launch our organisation's revised strategy, and part of that strategy is wider stakeholder engagement, including community engagement. It has been more difficult for us to have that in recent years, because of the pandemic. It is also about ensuring that people understand that we are a national service, whether they are in the central belt or in remote rural locations. I believe that there is an opportunity for our strategy to set out our vision but also to increase understanding of where NHS 24 sits as an integral part of the NHS in Scotland. A series of community and stakeholder engagement events are planned for when we launch our strategy, towards the end of this month.

Emma Harper: Thanks.

The Convener: I have a short question. You mentioned the redesign of urgent care and that the aim of that was to reduce self-presentation at accident and emergency units by between 15 and 20 per cent by 2026. Is that on track?

Jim Miller: It is a complex picture in the sense that we will view the demand records and whether we have been able to direct that demand into what we call flow navigation centres, which are areas within health boards that act as an alternative to

self-presentation at A and E. From that perspective, I think that we are absolutely on track. We are currently seeing a reduction of about 11 per cent—although it is sometimes as much as 15 per cent—in self-presentation in A and E. However, one of my colleagues from a territorial board might not see that 11 per cent reduction because there will be what we call displaced demand. It may be that people are coming from other areas, or they may have tried to access services and could not but will still go to A and E. There is no single route. However, the redesign of urgent care has been very significant.

One thing that I would suggest, almost as an interesting test of proof, is that the redesign of urgent care coincidentally tied in with the restrictions during Covid. It clearly was not intended to do that, but that was, in effect, where the timelines began. That was when NHS 24 began to provide a 24/7 service and we saw an immediate spike in demand—from Monday to Friday, from 9 to 5, including for the redesigned urgent care—simply because other services were not available.

As services opened up again, we were all really interested to see whether that demand would drop, but the demand has not dropped at all. In fact, it has remained incredibly static. We are therefore making the line of logic that that shows that the redesign of urgent care is working for people. Although other services are now available, it is working for them, particularly the access through NHS 24 into flow navigation centres.

09:30

Gillian Mackay (Central Scotland) (Green): What assessment has been made of the public awareness of mental health services that are available through NHS 24? Do patients on the whole know that they can access mental health support through NHS 24 and is the feedback that you are getting that they are comfortable using it, or is there still evidence that a lot of people are going to their GP or other places first?

Jim Miller: I believe that the expanded suite of mental health services in NHS 24 gives an insight into the future of the organisation. There are two primary mental health services provided—one is called breathing space and one is called the mental health hub. Breathing space is a long-established service and is well recognised and understood by local communities. The mental health hub is a more recent development, again coinciding with Covid. I think that there is more to do in making people aware of those services, and in that regard I reference my previous community engagement suggestion. However, the demand for those services has grown very significantly and continues to grow, which suggests that there is an awareness of and a value in them.

The services offer different interactions, and we are now looking to understand whether people are making a conscious decision about which service to use under that broad mental health service banner and how we more accurately signpost the variable services within breathing space, the mental health hub and our online self-help guides.

Gillian Mackay: At the moment, people under 16 are advised to phone Childline. Is there a plan to expand mental health provision for children and young people? Is there a benefit in providing a dedicated mental health service, such as breathing space or the other interventions you have mentioned, for children and young people in particular?

Jim Miller: We have seen demand, particularly in the close-to-16 age group. We need to be cautious in order to develop services that are safe and effective for younger people, and we are certainly looking at that. Complementary services are provided—for example, a significant amount of information on surviving suicidal thoughts is available digitally—and we have real demand for digital or video-based personal stories on how people have coped with their individual circumstances. The feedback that we have received from the analysis of that is that those are picked up by younger demographics, so we are considering what that means for us in the development of those services. The information may not be provided through direct telephony services but perhaps more digitally.

Gillian Mackay: Given the digital literacy of children and young people, is there a smaller volume than you might expect of children and young people phoning NHS 24 versus other interventions? Does that speak to the variety of things that we need to provide?

Jim Miller: We look at the demographics and age profile as well as the geographic profile, because we want to ensure that people are accessing our services wherever they are in Scotland and whatever age they are. You are absolutely right that the expectations of age groups are different. For example, we introduced something called a bot—do not ask me exactly what that means, but I think I understand—that allows people to have an exchange of information rather than speak to someone on the telephone. That was fantastically successful but, when we did the analysis, we found that more girls than boys used it—I say “girls” and “boys” because it was a younger demographic. The bot was most used by younger females. That is interesting data on how people choose to access the service.

I think that we all recognise that the younger age groups are much more likely to engage completely digitally than they are to pick up the telephone, which they may feel is old fashioned.

Gillian Mackay: Does that feed into some of the on-going service development of NHS 24? Are you looking at what suits the population now and what has to continue to develop, particularly in the mental health space, in the coming years?

Jim Miller: Absolutely. The NHS 24 online app is a way that people can access the service through digital means and then directly into a traditional telephony service. I still think that it is important that we keep multiple ways to access. Part of our 2025 programme is an omnichannel approach, which is a technology phrase that simply means that there is no wrong door and that people can access the service in whichever way they choose.

Carol Mochan (South Scotland) (Lab): Good morning. I have quite a specific question about the route through the mental health hub, which constituents have raised with us. When someone who is already known to mental health services phones NHS 24 and is looking to be directed onwards, is that a smooth flow through, or do people have to go through a number of assessments before being linked into the service where they are already known?

Jim Miller: With all the access points into NHS 24, it is important that we establish some core information. The skill of our call handlers is extraordinary because, very often, when people phone they are distressed and confused and they just want help, so they are unlikely to give the information in the right order, from A to Z. The skill of the call handler is to ensure that they bring the person back to the point so that we understand that we have established identity, that they are safe and then their reason for calling. I do not believe that those are unnecessary steps, but it is important that they get through those points as quickly and effectively as possible. That also allows a trust bond between the patient and the call handler at that point, and then the discussion takes place.

I believe that, wherever people access the service and that information, the onward routes are relatively smooth. However, we can do more. Very recently, we have introduced an ability to provide patient information to community pharmacy, which is a very important part of community-based services. We can now provide information to community pharmacy, and vice versa, to smooth that path. We have an ambition that we want people to be able to tell their story once. I do not think that we are there yet—I genuinely do not—but that is important to us, and I think that we are improving in that regard.

Carol Mochan: Thanks very much.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): Thank you for being here this morning. I have a couple of short questions. First, do you monitor whether you are getting repeat calls on distress brief intervention? Secondly, if a child or young person or their parent or carer calls you and they are in a great deal of distress, are they told to hang up and call another number?

Jim Miller: In answer to the first point on distress brief intervention, NHS 24 deals with over a third of all referrals into the DBI service. We are the single largest referral point, and it has been really useful. DBI level 1, which involves a compassionate approach, is contained in NHS 24. As I am sure you are aware, DBI level 2 is provided by a range of predominantly third sector providers. Almost by the nature of that service, we see repeat callers into DBI, into our mental health hub and, perhaps more so, into our breathing space service.

For me, one of the beauties of that service is that it does not matter whether you need us once or five times—we are still there to help. Where I think we have an opportunity is in considering whether alternative methods of help are available to people who have contacted those services regularly. The DBI service is very good at providing onward referrals. The issue that people need help with might not be a direct health issue; it might be a social, family or justice issue. DBI is a fabulous service.

Apologies, but would you mind repeating the second part of the question?

Stephanie Callaghan: It was about not providing direct support to children and young people. If a call comes in from a child or young person—they are not always bordering the 16 age group; they can be quite a lot younger now—or their parent or carer, and that child or young person is in real distress, are they told to hang up and call another number? How is that handled?

Jim Miller: No. Clearly, the situation depends on which service is involved and the nature of the distress. We ask whether there is someone there who can provide additional information or help if they are significantly distressed but we would not tell them to hang up.

Stephanie Callaghan: Is the next step in that process, for example, asking them to attend A and E if the situation is quite serious?

Jim Miller: If it was serious enough to attend A and E or to warrant calling 999, that is the referral that we would provide. Our 999 referrals are very static. For about 5.5 per cent of calls that come into NHS 24, the suggestion is that they warrant a 999 call and then as we move down the acuity

level into A and E, the percentages change. Regardless of the age of the individual who contacts us, the core triage system—the patient safety system that sits underneath it—remains absolutely stable.

Stephanie Callaghan: Thank you.

Paul Sweeney: Data has shown that the number of mental health related calls to NHS 24 increased from 20,434 in 2019 to 139,008 in 2022, which by my calculation is a 580 per cent increase, which is an extraordinary number. Has that overwhelmed you? It seems an incredible figure that is not necessarily proportionate to the extra resources that you have been able to put into the service. How have you been able to adapt to that significant increase in demand?

Jim Miller: As you say, the shape of the demand curve has been quite marked. The mental health hub was introduced in about 2019, so that was the immediate response, and it is available 24/7. Breathing space currently is not available 24/7; it is predominantly still available in out-of-hours periods. We immediately increased our capacity by genuinely being available 24/7 for mental health services. We also created a new role, certainly for NHS Scotland, which we call a psychological wellbeing practitioner. People find that post very attractive if they are looking to further their clinical career, so we have been fortunate in being able to fill the posts quickly. However, because the post gives people such a rich learning experience, we have found that they tend to move on within the NHS pretty quickly. There is a positive and a negative in that.

The investment that we have provided in mental health services has allowed us to get to almost our target figures in those services, and we have seen a commensurate increase in the ability to pick up the calls. However, there is no denying that the demand is and continues to be very high.

Paul Sweeney: It seems to be clear that the dental and mental health areas are significant parts of the overall healthcare system that are under serious pressure. How sustainable is it for NHS 24 to be the first point of contact, and how effective can it be to refer on when there is not the capacity in the other services to which you are signposting? Do you feel that that approach is sustainable as part of the overall model?

Jim Miller: We need to change to continue to be sustainable. I believe that organisations such as NHS 24 are exactly what will provide the sustainability of our health services moving forward, with alternative methods of access, information and connections. Although, as we talked about, we have a focus on the redesign of urgent care and accident and emergency—that acute setting—I firmly believe that we need to move further upstream, as I mentioned, into primary care and the preventative space by, for example, providing information on healthy living and dietary requirements. That can potentially remove the need for services.

09:45

There is also downstream activity, which is an area where I think we are in the foothills of the potential of NHS 24. For example, we could provide people with reassurance, information and advice when they have just been discharged from hospital and perhaps have an on-going condition to manage, which can be very stressful. We need to understand how we can work with community-based services and augment them to prevent people from becoming nervous and then potentially contacting their GP or requiring readmission to hospital.

I emphasise that those upstream and downstream services are fledgling now but, to give a specific response in relation to mental health and dental services, it is by looking upstream and downstream that we will achieve sustainability.

Paul Sweeney: The context is the severe budgetary pressures that are being faced by healthcare, so it is not just about demand. The mental health budget has, in effect, been frozen in cash terms this year, with the cut to mental health being restored to bring it back to the level that it was at last year. What impact has that had on your services? Have you been able to offer an alternative interface or are you feeling the pressure as well?

Jim Miller: There is no part of the health service that does not have keep a very close eye on the matter to make sure that it has a balanced budget, but also that it spends that budget effectively. That last point is important across all our services. We need to make sure that we look at how the services are being developed and whether they will continue to be fit for purpose, given the way that they are provided. We also need to recognise the users of those services and get feedback from them on what works for them and whether they would be willing—and, indeed, whether they would see it as additional value—for the services to be provided differently, such as via digital or a remote resource. Rather than changing the service and then asking people to react to that, we need to make sure that we put the patient's voice first and build services around that.

Paul Sweeney: My final question is about the interface between Police Scotland and NHS 24. We know that there has been an increase in the number of call-outs for the police to attend mental health-related incidents in the community. Do you refer people to the police? Are people contacting

NHS 24 instead of the police? Is that a more appropriate presentation? Can you provide any analysis of that?

Jim Miller: Yes. The three partners—the Scottish Ambulance Service, NHS 24 and Police Scotland—have done significant work to make sure that we work together in that space. Recently, we ran a programme whereby, instead of the police attending when they get a call-out, which can sometimes inflame a situation, they will refer the individual to the mental health hub. That judgment is made based on the particular circumstances at the time, and sometimes it is made on site, wherever the individual is. In some cases, rather than the police attending, they will respond by providing information about the mental health hub.

With the Scottish Ambulance Service and Police Scotland, we are working on how we can best operate in our three areas. Rather than cases being escalated and an ambulance or the police being required, can NHS 24 pick up the demand?

The Convener: We are getting a bit tight for time, so I ask for concise questions and answers, please. Emma Harper is next.

Emma Harper: We have talked a lot about distress brief interventions, breathing space and the mental health hub, and we know that a lot of work has been done to reduce stigma around mental health so that people feel that it is okay to reach out. How has Covid impacted the work to direct people to breathing space, DBIs and the mental health hub?

Jim Miller: I would never say that there was a positive from Covid. That would be completely the wrong thing to say. However, it has heightened the public's awareness of the services that NHS 24 can provide. With the additional investment to make sure that it is truly a 24/7 service, I think that the public have responded incredibly well in that regard. There is a positive aspect in that we have seen increased demand both from 9 to 5, Monday to Friday and at the traditional times that NHS 24 picks up, which are at weekends and out of hours.

Emma Harper: Does NHS 24 use a local information system for Scotland—ALISS—to direct folk to third sector organisations that provide help and support with regard to mental health issues, for instance? Is using ALISS or directing people to local third sector services using whatever apps are available locally part of the upstreaming and downstreaming plan?

Jim Miller: Yes. Scotland's service directory, which provides information on primary care services, GPs, pharmacies and so on, is embedded in both NHS Inform and the app. That allows people to pick up geographically specific data wherever they are, even if they are visiting another part of Scotland that they are not familiar with.

I believe that NHS Inform could be an enhanced national asset. It needs some work, and we have agreed with our Scottish Government colleagues that we will transform both the content and the way that people engage with it. That will pick up the exact point that you make about access to both direct and supplementary or complementary services in health.

The Convener: We will move on to our final theme with some questions from Evelyn Tweed.

Evelyn Tweed (Stirling) (SNP): Good morning, Jim. You mentioned blended roles when you discussed your work on recruitment and retention. Will you tell us more about the various strategies that NHS 24 is using for that?

Jim Miller: Yes. NHS 24 provides a very useful alternative to the traditional idea of 9 to 5, Monday to Friday employment. The vast majority of our staff operate on a part-time basis at times that may suit their requirements at a particular time. For example, they may be students or people with young families or other caring responsibilities, and they will fit the job around that. That is fabulous, but it means that we see a higher attrition rate than is seen in traditional employment, if I can put it in that way. The learning that we can take from that is to expect a higher turnover in those posts as people move on, go back to university or whatever.

We are considering how we can bring people in seamlessly and how we can ensure that the training is both effective and modern, with things such as gamification, so that people can learn before they start.

The most common question that I am asked is perhaps the one about home working versus being based in one our geographic centres. We are looking at that. We recognise that the workforce requirement has changed. However, it is really important for me and my colleagues—it is certainly important for me as accountable officer—that whatever service we provide is safe and effective for the patient.

We now have the ability for our clinical supervisors to be completely remote. They may be in the centre, in another centre, in a hospital location or at home. That is a very recent intervention, which perhaps makes it easier for people to have blended roles. For example, it might mean that someone who works at NHS Dumfries and Galloway can provide one or two days a week for NHS 24, knowing that they will not have to travel to the nearest centre. Those are the sorts of questions that we are asking ourselves.

We have found that the response to the remote clinical supervision has been that the vast majority of our nursing colleagues still like face-to-face contact and, although remote supervision is an option, our supervisors tend to come into the centre.

I am conscious of the time, so I will conclude my answer. These are incremental improvements. It may be that, for one shift or one instance a month, it would be more difficult for a person to attend work. If they are able to attend work remotely, I would rather they did that than not attend at all.

Evelyn Tweed: I note from your data that staff attendance is getting better over the months. In December 2022, the figure was 89.5 per cent. In May 2023, it was 92.5 per cent. What are you doing about staff wellbeing?

Jim Miller: I am really pleased to see that increase in staff availability because, frankly, the more staff we have, the less stress there is for them covering potential absences elsewhere in the team.

Wellbeing is critical to our staff in the NHS. We recognise that many of them work in areas that operate at 2 o'clock or 3 o'clock in the morning and on Saturdays and Sundays. Those staff have a very different working experience from people who work the traditional 9 to 5. We have supportive resources for staff. We are a significant user of the Thrive app, which is a mental health related self-help and diagnostic app. We have had very good uptake of that. We have our mental health charter, which all our colleagues are aware of. We also make sure that our digital resources are equally available for people who work out of hours. For example, if I need help with my wage slip, I can make a call to payroll if it is 2 o'clock in the afternoon, but I cannot do that if it is 2 o'clock in the morning. We are still effectively an out-of-hours service in terms of the shape of our demand, albeit that we are now 24/7.

Sue Webber (Lothian) (Con): I have a brief supplementary question about retention. You mentioned some of the things that you offer for flexible working, but you also spoke of your higher attrition rate, which is perhaps due to the nature of the people who come to you. What else are you doing to try to tackle the retention element and keep as staff in post for as long as possible?

Jim Miller: There are a number of things. We have introduced what we call stay conversations. Quite often, when you join an organisation, there is a period when you go through training or induction and then you are kind of left to it. We want to make sure that individuals do not feel that they have been left to it, so we have introduced stay conversations after 30 days, 60 days, six months and 12 months to make sure that there is a specific check-in point on how it is working for them. That is a relatively recent intervention, but I think that people are finding that, from both a manager's perspective and an individual's perspective, the protected time for those conversations provides a good touch point.

Learning from exit interviews is also important for us. In the NHS, exit interviews are voluntary, but we are making it as easy as possible for people to provide an exit interview and we are taking the learning from them. We also have a significant number of staff who move within the NHS. That takes me back to the question about blended roles. How can we share the wider resource across NHS Scotland? Are there opportunities for individuals to come back to us in NHS 24 after they have gained experience elsewhere?

Rather than concentrating on the reason for people leaving, we are trying to concentrate on the reasons why people would want to stay. I think that we have a very high quality workplace offering for people. Our workplaces are bright, airy, safe, secure and easy to access. We provide lots of on-site welfare and wellbeing opportunities. We also provide corporate access through to our human resources and workforce services and those opportunities for training and development.

Sue Webber: Everyone always wants more, but what else is there in the package that the staff get? It is not just about pay and pensions, is it? Do they get anything else that will encourage them to stay with NHS 24 or is that all predetermined nationally by the NHS? I am thinking of health facilities, gym facilities and all those sorts of things. I am not sure—I am maybe overreaching a little bit.

Jim Miller: That becomes a bit more difficult given that we need to make sure that we operate within the parameters of NHS Scotland. However, we are in an open conversation with our colleagues in Clydebank about accessing some council gym facilities. I hate the phrase "every little helps", but I think that it does, in that space.

It is really important that, when staff join NHS 24, particularly as call handlers, they understand the difference between an NHS 24 contact centre environment and where they have been or what they may have perceived that to be. It is a very challenging role. Again, I commend the absolute skill of our call handlers, which is mind blowing, but we do have people who find it very difficult within two or three weeks and who will say that it is simply too difficult for them. That is not good for them or for us, so we are developing situations where people can learn about the experience of working at NHS 24. We are trying to work with schools and colleges so that people can come along, understand the environment and then

decide whether it is for them, rather than making that choice and then finding that it is not.

Sue Webber: That is very helpful. Thank you.

10:00

The Convener: I declare an interest as a registered mental health nurse with current Nursing and Midwifery Council registration.

Having visited the NHS 24 mental health hub and seen the figures that you have presented to us on people accessing the service and the improvements to telephone access, I have a brief question about breathing space. Are there plans to expand access to that service outwith the core hours that it has now?

Jim Miller: There are no specific plans to expand the breathing space service, per se. This year, we are looking at how we can take the overall totality of our mental health services and treat them as a suite of services. We want to make sure that people are accessing services in an informed manner rather than, perhaps, someone who has used breathing space in the past using it again just because they have the number, even though their requirement right now may be better suited to the mental health hub. We need to do more of that, because it will effectively increase the capacity across the space.

The Convener: Thank you very much for coming along to the committee today, Mr Miller.

I will suspend the meeting briefly.

10:01

Meeting suspended.

10:10

On resuming—

The Convener: We continue our scrutiny of front-line NHS boards. I welcome to the committee Pauline Howie, who is the chief executive of the Scottish Ambulance Service. We move straight to questions. Will you detail exactly how the board plans to achieve the 3 per cent efficiency savings that are needed to achieve financial balance over the next three financial years?

Pauline Howie (Scottish Ambulance Service): Yes. We have in place a comprehensive best-value programme that each of our executive member teams leads an aspect of. They report directly into our 2030 strategy group, our audit committee and our board, which considers the financial position of the organisation at every single board meeting.

The plan looks across all our activities to identify the areas, for example, that we might have introduced in response to Covid and whether we can respond in a different way to some of the cost pressures. It looks to see how we can recover overtime costs, which have been significantly higher during Covid because of wider issues across the entire health and social care system. Members will be aware that our ambulance staff spend longer at the front door of hospitals, which adds to the time to complete each patient cycle and frequently results in staff being held back at the end of their shifts, resulting in more overtime. We are working very closely with other boards to identify ways in which we can more safely and effectively manage patients at the front door and ensure that our staff finish their shifts on time so that we can reduce overtime costs.

We are looking at electric vehicles, and we are about to prototype use of the first United Kingdom electric ambulance here in Scotland. We are working with vehicle manufacturers to identify more carbon-efficient ways of running our vehicle fleet. We are looking at LED lighting across our entire estate. We are looking at sharing services where it is entirely possible to do so. For example, we have shared payroll services across the NHS, we are working with the other emergency services on whether there is anything that we can do around emergency driver training and we work with the other UK ambulance services on joint procurement activities to identify savings where we can do something across the entire UK.

The Convener: That is helpful and leads on to other areas that I want to explore. To what extent can savings be expected to be sustainable in the longer term? I assume from what you have said that a lot of the joint working, cross-sector working and working with other parts of the NHS is part of the sustainability plan.

Pauline Howie: Absolutely. We are trying to get all the areas that we are looking at into a recurring financially sustainable position. You will see from our written submission that we do not think that that will be entirely possible this year. However, it is the plan over the three years of the financial planning cycle to get into a recurring financially sustainable position.

Sandesh Gulhane: I declare an interest as a practising NHS GP. I am interested in and want you to expand further on the electric ambulance, which is exciting. Will you tell us a little bit more about that and what its range is?

Pauline Howie: It is very much in development at the moment, but we expect it to be introduced into our fleet by the end of the year. We have not publicised that with the manufacturer yet, so there is very little that I can say, because I know that the manufacturer is desperate to do a proper launch with us. It is content not to be named today but for me to mention that we will be the first ambulance

service in the UK to bring an electric ambulance into service by the end of this year.

In Scotland, we obviously need the range to be significant because, as you can imagine, our ambulance fleet covers a significant number of miles not just in rural areas but in our more urban areas. Typically, an ambulance might cover 10 patients a day, and the fleet might stop and start in several areas, even across cities, and be deployed across, for example, the whole of Glasgow or Edinburgh. Our fleet covers significant miles, so we have been working on that with manufacturers in order to get a fleet that has sufficient range to enable us to be confident that it can satisfy our requirements.

10:15

Paul Sweeney: Thank you for joining us today. I have a question regarding the codes that were mentioned in your submission. You indicated that red and purple are assigned to emergency calls, but, despite those emergency markers, I understand that red or purple call patients can still wait hours to get a response. I am familiar with one constituency case in which a red call patient waited six hours and 50 minutes for a response. Paramedics and your team are trying exceptionally hard in impossible circumstances. What can the Scottish Government do to support the service and improve response times to such critical calls, and how can the system improve the flow of returns?

Pauline Howie: I am pleased to advise the committee that our response times across all call categories have been improving. That is principally to do with significant investment over the past three years in our accident and emergency demand and capacity reform programme, which has seen the introduction of an additional 458 ambulance posts into front-line services, an additional 52 ambulances and 10 new locations from which we deploy those ambulances. That is based on historical demand that has been updated as we have gone through the past few years.

The final cohort of the additional staff are currently in training. Those 80 ambulance technicians will finish their training by the end of this month, bringing us up to full complement plus 458 staff, as I said, which is already resulting in a significant improvement in our response times. We have aligned all our shift patterns to match demand as closely as possible while maintaining good practice, which includes, along with the new shifts, reviewing with the Health and Safety Executive our fatigue management for staff to try to improve their health and wellbeing.

The single biggest challenge now remains the hospital turnaround times. Although we have put in additional resource, the extra time that our staff spend at hospitals is depleting some of the additionality, which means that some patients continue to wait far too long. Red call patients, such as the patient whom you mentioned with that dreadful response time, tend to be patients who have started off on a lower acuity level but, because our clinical advisers have become concerned that the patient might be deteriorating, whose call has been upgraded to get a quicker response to them. We are working very closely with the supplier of our command and control system so that we can record those two times separately, to see the difference in times between the patients who start as a yellow call and are upgraded and the patients who start off in a red or purple higher acuity category.

Paul Sweeney: From what you are saying, that certainly sounds like a promising process improvement, and I hope that it will yield significant results. You mentioned that one of the key sticking points is the interface with emergency departments at acute hospitals. Last week, we heard about a pilot that is being trialled in some health boards to ease demand on emergency departments, whereby ambulance crews phone ahead to speak to an emergency medicine consultant, who decides whether it is best for the patient to be presented to the A and E department or to a different facility. Do you have an insight on the system that is being trialled? Could it be scaled up to ease demand on emergency departments on a national scale?

Pauline Howie: I think that you are talking about flow navigation, which most health systems in Scotland have in one form or another. It has been tried out in different ways across the country. Perhaps one of the most successful approaches is in the NHS Grampian area, in which, for 70 per cent of the yellow call or lower acuity patients, our staff phone the flow navigation centre before they convey the patient to seek further senior clinical support. With the senior clinician in the flow navigation centre, our staff take a decision with and for the patient to reach an outcome that all parties decide is best for the patient at that particular time. That might be to in-hours or out-of-hours GP services; it might be directly into mental health pathways; or it might be into the falls and frailty pathway.

We are working with all boards on developing flow navigation centres. We have developed criteria for what “good” looks like from an ambulance perspective in being able to get quick access. Obviously, our staff are in emergency situations, and they want to be confident that they can get a response as quickly as possible—preferably 24/7 access—for when patients need them. In particular, elderly patients’ falls tend to

happen out of hours, so we need support out of hours for clinical decisions related to those.

We are developing a range of different pathways with services across the country, such as community respiratory services. Those are now being shared across all NHS boards, and we are working with boards to implement them as far as possible before the winter.

Paul Sweeney: You mentioned that flow navigation is implemented in one form or another across all territorial boards. You are in a fairly unique position in that you sit across all those boards and have that perspective. How dynamic and adaptive are the territorial boards in sharing best practice? Are you able to indicate where approaches are doing well elsewhere that could be adapted across the nation as a whole and bring everyone up to a higher performance level?

Pauline Howie: Yes. We are part of the urgent and unscheduled care collaborative across all boards, the Scottish Ambulance Service, NHS 24 and Healthcare Improvement Scotland. We are all involved in that, which is very much about learning together, sharing good practice and understanding what works in one system and whether it can be applied in another system. You will be aware that part of the challenge in implementing exactly the same approach in other systems is demographics, workforce availability and geographical issues.

Sandesh Gulhane: You spoke earlier about the difference between patients being categorised highly and their being upgraded. The concern is that someone might have waited so long that their condition has deteriorated, thus requiring the upgrade. Do you recognise that, even though someone might have waited in the yellow category, once they have become red category, it is then a red category waiting time, so it is not a separate thing?

Pauline Howie: Categorising is mainly for us to understand the upgrade or downgrade. There would be no process change whatsoever from the patient experience perspective. Last winter, to improve our safety netting of those calls, we introduced the integrated clinical hub. It is staffed by GPs, advanced paramedic and nurse practitioners and paramedics who, for not immediately life-threatening calls, safety net the patients. They look to see how long a patient has been waiting, provide a call-back to them and work out the best pathway for the patient at a particular point. Our senior clinical decision makers help us to provide that underpinning safety net.

Sandesh Gulhane: Is that tied into NHS 24 or is it separate?

Pauline Howie: It is separate from NHS 24. It handles 999 calls that are sitting awaiting an ambulance response and that are not immediately life-threatening. In addition, if we get calls from healthcare professionals about cases that are potentially much lower acuity but might have been waiting too long, hub staff safety net those calls and try to find the best pathway for them. Similar to flow navigation centres, hub staff are able to identify that many calls that come through healthcare professionals and from 999 callers do not require an emergency ambulance at that particular time. Often, different pathways are better for those patients—such as respiratory pathways, mental health pathways and falls and frailty pathways.

Sandesh Gulhane: Absolutely—there are different options.

An issue that I have as a GP is around the fair reflection that I provide when I ask for an ambulance. I might feel that a patient can manage a four-hour ambulance wait, but I—and a lot of us—invariably consider that that means an eight-hour ambulance wait, so I might upgrade it to two hours or one hour. If I do not, the patient will not get in. How can you reassure healthcare professionals who call you to say, “We need an ambulance for this patient, and this is the realistic timescale” that you can meet the timescale that they—the GP or other healthcare professional—have given you?

Pauline Howie: Our demand and capacity reform programme built in some of those parameters. We have also been investing in lower acuity card 46 resources, which are for referrals from GPs and other healthcare professionals that are not time critical. We understand what the acuity and intervention levels are for those patients en route, and, if possible, they are serviced by our ambulance technicians and ambulance care assistants.

As part of the cost pressure work that I mentioned earlier, we have invested in card 46 resources so that we can provide a quicker response. We are not yet where we want to be with healthcare professional calls, but it is certainly our plan to further develop our card 46 resource tier so that we can service those calls much more quickly than at present. However, it has been improving, and we continue to remain committed to making further improvements.

Evelyn Tweed: Good morning. I want to ask about the response time definition change. I understand that, for all UK ambulance services, that changed on 1 April 2022. What does the change mean for staff and what does it mean for patients?

Pauline Howie: The response time definition change was in response to significant extensive consultation that we carried out with the public and our staff, who were concerned that our sole focus

was on response time and believed that we needed to broaden our horizon to focus on clinical outcomes and patient experience as well. Therefore, now, as well as looking at, for example, an average response time within eight minutes for immediately life-threatening calls, we monitor our median response time and our 95th percentile, so that we are looking at those patients at the tail who might be waiting too long. Looking at both those measures enables us to identify where there are opportunities for improvement and to target our improvement activity much more effectively than before.

On our clinical outcome measures, we have been working with international organisations to ensure that we can compare and benchmark our performance with others. For example, our out-of-hospital cardiac arrest performance standards are all internationally recognised performance standards. We continue to work to improve our survival from cardiac arrest rates. You will be aware that we have also introduced the major trauma services across Scotland, and, again, we measure our performance against internationally recognised standards in that regard, and we do likewise for stroke.

It is a much broader, more extensive measurement framework that staff recognise and that our patients feel is much more meaningful for them, but which still maintains that focus on response times. For the immediately life-threatening calls, we have our purple calls for our most seriously unwell patients who are at risk of deterioration—the time-critical cases—and the median response target time for them now is six minutes rather than the eight minutes that it was before. For our red calls—our seriously ill patients—the median response target is seven minutes.

Evelyn Tweed: Do you feel that there still needs to be more education for the public with regard to when they phone you? Do we need to keep putting that message out? I know that work has been done in the past, but do we need to keep doing that to make sure they are going to the right place and getting the right help at the right time?

Pauline Howie: We work very closely with colleagues across NHS Scotland and Scottish Government to send right place, right care, right time messages to try to inform people about the best service for them at that particular time. I think that we need to continue to do that, particularly as we change services and adapt changes to meet the changing health needs of the population.

Carol Mochan: I am interested in the response times that you were talking about and the confidence that the public should have in the newer model that you have. Have you undertaken any evaluation of how those response times are working for patients and their families?

Pauline Howie: We are constantly evaluating our practice. I mentioned some of those clinical measures. We have the best ever clinical outcome for our purple category: a 56 per cent survival rate, which is superb. However, we are never complacent about the opportunities to do more for the most seriously unwell patients.

We do a range of activities, working with patient focus groups and public involvement groups. We also are members of Care Opinion, so we welcome feedback, good and less good. We view all feedback as a learning opportunity and we take on board that feedback. We have comprehensive systems of governance to make sure that we take on board all the learning that we gather, whether from adverse events, thank you notes or Care Opinion, and build that into our improvement plan.

10:30

Carol Mochan: As I am sure that you well know, the public hugely values the service, but there are definite problems in the system, particularly around ambulances being available for people. What key things do you recommend that the committee could ask for or speak to the Scottish Government about with regard to the delays that people have, particularly in life-threatening situations?

Pauline Howie: We try to minimise those life-threatening delays through the safety netting that I spoke about. We are getting quicker all the time. May’s performance was much better than April’s and we continue to focus on getting additional staff into place at the right time and making sure that our staff are appropriately trained and developed. As I said before, the single biggest issue is the turnaround challenge. It is complex. It is a reflection of the wider capacity challenges, not just in the emergency departments and hospitals but across health and social care, and in relation to delayed discharges. We are also working closely with health boards, the Scottish Government and integration joint boards on how we can create capacity.

One of our successes over the past few years has been the ability to recruit and retain staff. We still remain a very attractive employer and the BSc paramedic science undergraduate programme is well oversubscribed—it is one of the most oversubscribed courses in Scottish universities. We are working to see whether there are other ways in which we can help people into careers, and not just within the Scottish Ambulance Service—paramedics and ambulance technicians are highly qualified members of staff that we can use in various areas of service provision. For

example, we have paramedics and advanced paramedics working in GP out-of-hours services and in-hours services doing home visits on behalf of GPs, and we have some staff working at the front door of accident and emergency departments to help out with staffing. We are working with boards to understand the potential of that to perhaps help with some of their workforce challenges.

Gillian Mackay: On the clinical response model, I note that a public engagement exercise that was undertaken into the new clinical response model found that more than 90 per cent of the public supported it. That is encouraging, but what assessment has been made of the public's on-going awareness of the new clinical response model?

Pauline Howie: It has been in place now for several years, since 2017, so it is the clinical response model. As I mentioned earlier, we are constantly looking for feedback from patients, staff and other stakeholders, and we take on board that feedback. For example, in one of the evaluations that we did a couple of years ago, we noticed that patients with breathing difficulties had a higher cardiac arrest rate than we initially thought, so we upgraded that category into the purple response category—it was previously in red—to help to improve outcomes for those patients.

I mentioned falls and frailty services. We have been doing a lot of work on accessibility of falls pathways and being able to make direct referrals from people's homes into rapid assessment teams from falls services and for follow-up care from those services. We often find that, when we get into people's homes, particularly the more elderly members of our population, they do not want to go to hospital. They look for us to help find alternative pathways for them so that they can maintain their independence at home.

Gillian Mackay: Obviously, at times when people phone the Ambulance Service they are in acute distress or in acute need of help. Is there on-going assessment of how those calls are handled, the experience of call handlers, and how those response times and categorisations are communicated to people who are waiting?

Pauline Howie: Yes. We constantly review the call-handling scripts, as we call them. You will understand that there is very strict governance around those scripts. There is an international academy into which we feed our experience—our data and the experience of our staff and our patients—so that we can constantly refine those scripts and make sure that they are up to the current best practice, based on what we know and any research findings that we have been able to develop internally with Scottish universities or learn from international practice.

Gillian Mackay: That is great. To what extent is the Scottish Ambulance Service confident that the public are supportive of the new triage system in particular?

Pauline Howie: As your colleague said, the Scottish public value the Ambulance Service highly. We do not get many complaints at all about our response to patients in immediately life-threatening situations. As I said earlier, there is more that we want to do and more that we need to do for the patients who have been waiting too long and are in the lower acuity categories, and that is where our focus is: how can we get response times improved for those patients? The key enabler of that now is getting our ambulance crews turned around quicker at the front door of departments so that we can get back out responding to those patients, as well as doing the work in our integrated clinical hub to identify alternatives for patients at the point of call, and through the flow navigation support, which involves trying to identify alternatives so that, for those patients who do not want or need to go to hospital, there are alternatives that can help them to get into the right pathway of care for their presenting condition.

Emma Harper: Good morning. You mentioned falls earlier. I am just looking at the "Our 2030 Strategy" document, which says that 12 per cent of ambulance call-outs are for somebody who has fallen, so there is work being done to look at that. However, 10 per cent of call-outs are for patients with respiratory difficulties such as chronic obstructive pulmonary disease—COPD—exacerbation. As a co-convener of the cross-party group on lung health, I am interested in what work is being done to help to support the respiratory patients, for instance, because they might need not an admission but a referral to an onward pathway for better management of their COPD.

Pauline Howie: Indeed. Falls, respiratory and mental health pathways are the top three pathways that we are working on with boards and IJBs to try to get direct referral and to enable our staff to direct refer or to seek support and advice from those specialists.

Respiratory patients often are known to respiratory specialists and are part of community respiratory nursing teams, but many of them might not be or might not have accessed that service before. We have found, through a series of workstreams, that we are often in contact with patients who might not be users of those specialist services, so we can connect them in and help them to get a more effective treatment pathway in place. We do not have widespread coverage of respiratory pathways, but we are working with each system to try to encourage the adoption of good practice and to have the respiratory

pathways available for our staff at the times when patients present with them, which is often outwith 9 to 5.

The Convener: We will move on to our next theme, which Sue Webber will lead on.

Sue Webber: You will know that the NHS has a target to reduce sickness absence to less than 5 per cent. However, your submission notes that the sickness absence rate in the Ambulance Service is 8.9 per cent, and that you have a high proportion of staff with mental or physical health problems compared to other sections. What is your current sickness absence rate if the Covid-related absences are removed? What are the main underlying causes of those non-Covid absences? Is it still the musculoskeletal and physical pain aspects?

Pauline Howie: Our sickness absence rate for May 2023 was 7.6 per cent. Typically, the Covid element of that is between 0.5 and 1 per cent in the Scottish Ambulance Service.

Staff health and wellbeing is one of our top organisational priorities. Since my previous appearance before the committee, we have launched our integrated staff health and wellbeing strategy, which is about focusing on healthy body, healthy mind, healthy lifestyle, healthy culture and healthy environment for our staff. It was co-designed with our staff, and we also looked for international best practice, as well as working with the other emergency services, other UK ambulance services and other public services, including health boards here in Scotland. It is a comprehensive strategy to support staff to be well at work and, when they become unwell, to help them to return to work as quickly as possible.

Through that strategy, we have invested in additional specialist staff. We have additional health and wellbeing specialist staff and organisational development staff, who have a very detailed action plan that they are progressing with some vigour. Those actions include things such as trauma risk management training. That is an initiative whereby people in our service, who perhaps have higher exposure to traumatic events than other healthcare professionals because of the nature of the work that they do, can get support from peers. We have recently put 60 ambulance staff through TRiM practitioner training, and they will support the rest of the organisation. The training was hugely oversubscribed: we asked for 60 volunteers, and 250 volunteers came forward to support staff. Just before the Covid pandemic, we tested out TRiM training and TRiM practice in a couple of locations and it was very successfully received, so that has now been rolled out.

We have peer supporters in place across our whole organisation as well, so that people who just want to chat can chat. We also have financial wellbeing support for staff and links to citizens advice bureaux and other services, because we often find that issues that affect the mental wellbeing of our staff involve not only work-related issues but wider societal issues as well.

The top reasons for sickness absence, apart from Covid, remain anxiety, stress, depression, back problems and musculoskeletal problems. When we were developing our strategy, it was apparent that ambulance services worldwide suffer higher rates of sickness absence than other parts of the health and social care system. Part of that is because of the psychological risks that the staff face, part of it involves the physicality of the work that they do, and part of it involves the exposure to traumatic events—often not individual events but repeated exposure—which is why we are putting so much emphasis on healthy mind activities.

We also have a series of staff-organised events, such as the West Lothian breakfast club, which is a drop-in club—it is a social event where people can come together. It is not just for our staff; it has been extended to the other emergency services and parts of the NHS in West Lothian. We have walk-in clubs in place. We have discounted gym membership for staff across most local authority areas, too.

The demand and capacity programme that I mentioned earlier has taken a bit of the pressure off staff. When we ask staff what matters to them, they tell us that management of demand is one of the biggest stressors in relation to their time at work. Having additional resources to help to manage the demand and having those resources on at the right time and in the right place is helping. Again, if we can get that turnaround issue dealt with, that will help more people finish their shift on time and get back to their families and be fresher for the next shift.

Sue Webber: That precludes my second question, because there was so much in the answer. Briefly, on the evaluation of all those systems or the things that you are putting in place, do you have something to assess how they are working and what impact they will have?

Pauline Howie: Yes. As part of our health and wellbeing strategy, we have developed evaluation models and performance data. Some of it is hard information such as the sickness absence rate, the length of absence, the type of absence, and some of involves information from surveys of what matters to staff, the iMatter survey and staff engagement events. We do a lot of station walkabouts and we have an online weekly event with staff where they can ask anything. We arrange activities around themses. For example, two weeks ago we did a culture week within the

service, where we had various external speakers on culture and environment across the service. We use a range of different measurements to evaluate the effectiveness of our health and wellbeing strategy.

10:45

The Convener: That ties in well with the questions that Sandesh Gulhane has for you.

Sandesh Gulhane: Absolutely. You gave a very full answer to Sue Webber. In the past 12 months, what has been the attrition rate of your advanced paramedics?

Pauline Howie: The rate for advanced paramedics is higher than that for our base workforce. I believe that it is over 12 per cent. I do not have the figure in my head at the moment, but I can come back to you on that.

Sandesh Gulhane: So, the figure is roughly that.

Pauline Howie: Yes.

Sandesh Gulhane: I have been contacted by paramedics about all the things that you are doing. One paramedic said to me that she suffered from numerous traumatic situations and from post-traumatic stress disorder. She wanted to go into the triaging area because she simply wanted to be away from the front-line environment, but she was forced to quit because she was told that she had to go to the front line and had to be in ambulances. I have also been contacted by advanced paramedics who have said that they absolutely do not like the fact that they only triage and they are not getting out. What would you say to those paramedics?

Pauline Howie: Obviously, I do not know the specifics of the first case that you mentioned. If you want to contact me after the meeting, I would be happy to try to understand the particular circumstances.

There is now a range of opportunities for paramedics that have never been there before—not just in the clinical triage arrangements but in education and professional development. I mentioned the BSc paramedic science course that is now available. We continue to develop various opportunities for our staff.

There is a 30/30/30 per cent opportunity for the advanced practitioners: 30 per cent of their time will be spent in remote triage, 30 per cent will typically be spent working with GP in-hours or out-of-hours services, and 30 per cent will be spent supporting immediate responses to patients through the 999 system or through the healthcare professionals system. We continue to work with advanced practitioners on role development.

The role is a really new one. It was introduced quickly at the very beginning of the pandemic in order to safely respond to patients and identify patients who required an immediate ambulance response. We have continued to refine the role since we introduced the model in April 2020. The feedback from those practitioners has been essential to that. They are highly valued members of staff across the whole health and social care environment, as I am sure you are aware.

Sandesh Gulhane: What if an advanced paramedic came to you and said, “Look, I don’t like this 30/30/30. I want to be out there more. I want to be seeing patients more.”? Is there flexibility for them?

Pauline Howie: The arrangement that we currently have in place is the 30/30/30 split that I have spoken about. However, as I said, we are continuing to refine that model. We find that some staff prefer to do the remote triaging to the response to—

Sandesh Gulhane: Absolutely. If you have that—

Pauline Howie: That is very much work in progress.

The Convener: Mr Gulhane, please let the witness answer.

Pauline Howie: We are working with that team and continuing to evolve the model so that we can get the best out of people. As you know, they are very experienced and highly qualified staff. We have shown and proved that the work that they do in remote triage is very effective, and the feedback from patients is very high.

Sandesh Gulhane: If some paramedics enjoy the triaging and some paramedics do not enjoy it, surely it would make sense to allow them to do the bits that they really enjoy.

Pauline Howie: In an ideal world, it would. However, we need to make sure that we have enough people doing the triaging and enough people for the responses. I mentioned that work on that is in progress. We are modelling the numbers that we need to do both, and we are trying to make sure that we have the right people with the right skills in those places to support colleagues and patients.

Sandesh Gulhane: Finally, when you do your exit interviews, especially for advanced paramedics who are leaving the service, what reasons do people give for leaving the service?

Pauline Howie: I do not know that off the top of my head. However, I can tell you anecdotally that some of them tell me that there are opportunities in other parts of the health service. Often, part of the reason is pay in, for example, GP practices,

which directly employ our advanced practitioners. Other reasons are the opportunities in out-of-hours services or in-hour services in different parts of the service. I can certainly get that information to you.

Sandesh Gulhane: Thank you.

Stephanie Callaghan: We have heard about a lot of fantastic work that is going on locally and nationally. For example, there is the introduction of the hospital ambulance liaison officers—HALO is a very apt acronym. Consultant Connect is really interesting. Direct contact between the Scottish Ambulance Service and senior clinicians allows remote decisions to be made in minutes and saves going through accident and emergency, which prevents waits.

I heard recently in relation to the Lanarkshire local police plan—about 10 per cent of the demand for police forces in Scotland is in that area—that mental health is becoming a really significant issue and that the approach is not sustainable. What work is going on with Police Scotland to create direct links to give it support and reduce the amount of time that the police spend in A and E departments? For example, one evening, Police Scotland had all five cars there at A and E. I am interested in any pilots or any work that is going on to improve things and the impact that that is having.

Pauline Howie: We work closely with Police Scotland and the Scottish Fire and Rescue Service, and mental health is one of the top priorities of all three services. You will probably have heard from Jim Miller earlier today about the work that we do with NHS 24 and Police Scotland in respect of the mental health triage hub that is hosted by NHS 24. Scottish Ambulance Service staff, control room staff and Police Scotland staff can refer people who are in distress to that mental health triage hub.

In February this year, we introduced a service through which police officers can call ambulance control direct from the scene. They can get support with clinical decision making for people whom they are worried about at the scene. We have found that over 46 per cent of the calls from police officers at the scene are in the yellow category, and we do not convey about 40 per cent of those patients to hospital. We are trying to work with Police Scotland to understand exactly what those patients' needs are and how we can develop alternative pathways that are more appropriate to their needs at that particular time.

The feedback from Police Scotland so far has been very positive. There is an average pick-up time of four seconds for its calls, and it is very reassuring for police officers at the scene that they are able to contact a healthcare professional and get advice. If something is more serious—if, for example, there is a red call, a road traffic collision, a stabbing or a seizure—we can get our support to police officers as quickly as possible. While the ambulance is on the way, we provide clinical decision support by radio to the police officers on the scene.

Stephanie Callaghan: Fantastic. Thank you.

Emma Harper: In the previous parliamentary session, I was a member of the Health and Sport Committee. We heard from the Scottish Ambulance Service about how, for instance, the police ended up looking after people in emergency rooms, which took up their time. I am interested to know what work has been done to support the police in dealing with NHS calls and whether the Scottish Ambulance Service or other parts of NHS could do that.

Pauline Howie: I mentioned the work around police officers being able to contact us directly from the scene and 40 per cent of the yellow category patients not requiring conveyance to emergency departments. We are working with Police Scotland to understand what the best pathway is for the person at that particular time.

The last time I was here, I might have mentioned the mental health triage car, which we were staffing at that time with a paramedic, a police officer and a mental health nurse. We have learned from that and taken on board the feedback, and we now have three mental health cars in Scotland—one in Glasgow, one in Dundee and one in Inverness—which are staffed solely by a mental health nurse and a paramedic. Where we require police assistance, they will move there on call. That saves police officer time, as well.

We are doing specific work with Police Scotland officers and our staff on suicide prevention and support for people who may be contemplating suicide, and providing other joint training opportunities for police officers, paramedics and ambulance staff.

We are constantly looking for ways in which we can support one another in dealing with more vulnerable people who might be in mental health crisis. We now have a high-intensity users team in the Scottish Ambulance Service for people who are regular callers to us. We often find that many of those callers have underlying mental health conditions. We can connect them with other parts of the system and make sure that appropriate support arrangements are in place.

Drug harm reduction is another area in which we work very closely with Police Scotland. We now have all our staff trained in, and we have kits for, the take-home naloxone programme. We have handed out more than 2,600 kits to families or friends of people who have contacted us about a

drug overdose to try to support people who might overdose in the future.

We are also working to see what more we can do around community safety initiatives and connecting people who might have overdosed with rehab and treatment services. We have found that 40 per cent of people whom we have attended were not in treatment services. We have been able to make contact on behalf of those patients, with their permission, with treatment services to support them. I hope that that will stop the cycles of repeated overdose.

Emma Harper: I am thinking about liaison with not just the police but the fire service. I am sure that that is part of on-going work. I am also interested in the work that is done to engage with people who use drugs and alcohol harmfully, and to reduce the stigma. Are tackling or addressing stigma and the language that we use part of the continuing professional development that is provided for Scottish Ambulance Service staff?

Pauline Howie: Absolutely. We got additional funding from the Scottish Government to employ specialist mental health teams in the Scottish Ambulance Service. They have embarked on a wholesale education and development programme for all our staff. For example, a couple of weeks ago, they were in our ambulance control centre supporting our call-handling staff in respect of mental health patients. The issues that they have been dealing with include stigma and language. The training and education programme is for all staff in our service.

Emma Harper: Do you monitor situations in which someone who has a mental health emergency or an urgent need of that kind is engaged with by the police rather than by the Ambulance Service? Do you track occasions on which the police, rather than ambulance crew, escort someone to the emergency department?

Pauline Howie: We do not specifically track that, but the police do. That is part of the work that we are trying to do with Police Scotland and the Scottish Fire and Rescue Service and with Public Health Scotland, which we share all our data with. It can work to interpret and analyse the data on our behalf. We need to make sure that we respect confidentiality issues in sharing that data, but that work is part of our work programme with the Scottish Fire and Rescue Service and Police Scotland.

We have a comprehensive collaboration programme that includes workstreams around knowledge and intelligence sharing, what the data tells us about users of our service and where we can identify opportunities to take a more proactive and preventative approach across the three emergency services. Rather than constantly responding to the same people, we want to try to get them on to more appropriate pathways where they can be treated and managed in the future.

11:00

Emma Harper: Can I ask a final question, convener?

The Convener: A number of members want to come in, so only if it is very brief.

Emma Harper: I will wait and bring the issue up later, because I think that it will be worth a letter. It concerns maternity services and delivering babies in ambulances in rural areas, for instance. I can pick that up later.

The Convener: I declare an interest as a registered mental health nurse with a current Nursing and Midwifery Council registration. Has there been any assessment of the impact of the mental health assessment units that have been established across the country on ambulance waiting times at A and E?

Pauline Howie: I do not have that information to hand, but I can certainly get it. Direct access to mental health assessment units for patients who present through the 999 system is one of the top pathways that we are trying to develop.

The Convener: Thank you. I would be grateful if you could provide that information.

Paul Sweeney: I want to pick up an issue that is frequently raised by police officers, which is the amount of time that they spend dealing with cases that they do not feel qualified to address or capable of dealing with. The number of calls made to Police Scotland in which a mental health crisis or a suicide risk was cited increased by almost 10,000, from 14,540 in 2018 to 23,406 in 2022.

You mentioned the pilot of triage cars, three of which are operating in Scotland at the moment. Do you feel that there is an opportunity to look at a business case to expand that model if it is shown to be a more effective and more cost-effective solution, given the huge costs that are incurred by the police in responding to incidents involving people who have a known history of calling the police on such issues or incidents with which they are not qualified to deal when they arrive at the scene?

Pauline Howie: It might be the case that that is the most appropriate response. In the work that we are doing with Police Scotland at the moment, we are trying to get behind that data to understand what a person in that situation needs at the time that Police Scotland responds in order to develop more appropriate alternatives that are serviced by the agency that is most appropriate for that person at the time.

I mentioned earlier the direct referrals that police officers on the scene can now make. We are getting about 1,300 referrals each month from police officers on the scene, as well as the substantial number of referrals that we get direct from police control. Work is in progress to understand what people's needs are and to work with Police Scotland and other agencies to put in place more effective services for those people.

The Convener: Stephanie Callaghan wants to come back in on one of the issues that she raised earlier.

Stephanie Callaghan: Thank you for allowing me to come back in, convener.

I go back to something that Emma Harper said. I cannot really remember all the specifics around this; I am not sure whether you will be able to answer. I know from conversations that I have had that the Lanarkshire drug deaths prevention group has raised issues around information sharing, which you touched on before. It said that there was real fear around the general data protection regulation. One of its big concerns was about its inability to get non-fatal overdose information, given that those who die from an overdose will usually have tried before. Are you able to comment on that? Are there issues around that? Is that situation being tackled?

Pauline Howie: There are often challenges around GDPR, but we try to work with other agencies to understand why we are asked to share data and to understand what harm could be avoided through our being able to share that data. We look for opportunities to share data where it will prevent harm and lead to service development in the future. I am not specifically aware of the work that is being done with the Lanarkshire alcohol and drug partnership but, again, I would be happy to pick that up with you outwith the committee if there are particular challenges in that respect.

Stephanie Callaghan: That is helpful—thank you.

The Convener: I thank Pauline Howie for her attendance today.

Subordinate Legislation

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

11:04

The Convener: The next item on our agenda is consideration of two negative instruments. The first instrument is SSI 2023/161, the purpose of which is to list offences in relation to which compliance notices, as set out in the Food (Scotland) Act 2015, may be used as an alternative to criminal proceedings. The relevant offences relate to food information, food composition standards, novel foods, foods for specific groups and food contact materials.

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 13 June 2023 and has drawn the Parliament's attention to a cross-referencing error: paragraph 33 of the schedule should refer to regulation 4 of the Novel Foods (Scotland) Regulations 2017 instead of regulation 6(2). The committee noted that the Scottish Government intends to correct that error at the earliest opportunity. No motion to annul has been lodged in relation to the instrument. Do members have any comments to make?

Emma Harper: I do. Given my interest in food standards and how we are altering and changing them as we engage in things such as novel foods, I am interested in paragraph 9 of the policy note, which is about monitoring. It says:

> "Food Standards Scotland will work with Local Authorities where problems or suspected infringements of the legislation arise."

I am interested to know—we might need to write to Food Standards Scotland about this—how Food Standards Scotland will work with local authorities. How will we monitor that? I ask that out of general interest.

The Convener: Is the committee content to write to FSS on that basis?

Members *indicated agreement.*

The Convener: Thank you. Can I confirm that the committee has no recommendations to make on the instrument?

Members *indicated agreement.*

National Health Service (Charges to Overseas Visitors) (Scotland) Amendment Regulations 2023 (SSI 2023/173)

The Convener: The purpose of the second instrument, SSI 2023/173, is to ensure that overseas visitors from certain British overseas territories will not be charged for certain treatment provided by health boards in Scotland, in accordance with healthcare agreements. The instrument inserts a further five territories—Ascension Island, Bermuda, Cayman Islands, Pitcairn, Henderson, Ducie and Oeno Islands, and Tristan da Cunha—into schedule 2 of the National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989.

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 13 June 2023 and made no recommendations on it. No motion to annul has been lodged. Do members have any comments?

Members *indicated disagreement.*

The Convener: As members have no comments, I propose that the committee makes no recommendations on the instrument. Is that agreed?

Members *indicated agreement.*

The Convener: Thank you very much. Our next meeting will be a session with the Cabinet Secretary for NHS Recovery, Health and Social Care based on the evidence that we have gathered as part of our recent scrutiny of front-line NHS boards.

That concludes the public part of today’s meeting.

11:08

Meeting continued in private until 11:44.

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

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