OFFICIAL REPORT
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Health, Social Care and Sport Committee

Tuesday 5 December 2023

Session 6

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
37th Meeting 2023, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Neil Carnegie (Royal College of Occupational Therapists)
Derek Laidler (Chartered Society of Physiotherapy)
Catherine Shaw (NHS Highland)
Sharon Wiener-Ogilvie (Allied Health Professions Federation Scotland)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 5 December 2023

[The Convener opened the meeting at 09:15]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning and welcome to the 37th meeting in 2023 of the Health, Social Care and Sport Committee. I have received apologies from Paul Sweeney. The first item on our agenda is to decide whether to take in private items 3, 4, 5 and 6, and whether to consider in private at future meetings the evidence that is heard as part of our inquiry into remote and rural healthcare. Do members agree to do so?

Members *indicated agreement.*

Healthcare in Remote and Rural Areas

09:15

The Convener: Our second item is the committee's third oral evidence session of its inquiry into healthcare in remote and rural areas. We will hear from representatives of allied health professionals and nursing. I welcome Neil Carnegie, manager of the community occupational therapy team in Kirkcaldy, and of postural management for Fife Health and Social Care Partnership, and member of the Royal College of Occupational Therapists; David Laidler, professional lead physiotherapist in Argyll and Bute at the Lorn and Islands hospital, and member of the Chartered Society of Physiotherapy; Catherine Shaw, who joins us remotely, is lead advanced practitioner for the remote and rural support team in NHS Highland; and Sharon Wiener-Ogilvie is vice-chair of the Allied Health Professions Federation Scotland. We move straight to questions.

Sandesh Gulhane (Glasgow) (Con): Good morning to the panel. I start with a declaration of interest as a practising national health service general practitioner.

Among the many things that we talk about when it comes to rural healthcare, a big one is the 2018 GP contract, the point of which was to ensure a lot of allied health professionals in primary care. The idea was to take the pressure off GPs. Allied health professionals probably do a better job in many of the specific things that they choose to do. Musculoskeletal work is much better in physio, for example. However, and I have a quote,

> "The new Scottish GP contract has been a complete failure based on unachievable promises. At a national level it appeared a sound plan"

but

> "In rural areas there were never going to be enough pharmacists, physios, mental health workers and nursing staff to make this work".

I turn to Sharon Wiener-Ogilvie first. Is that true? If so, what should we do?

Sharon Wiener-Ogilvie (Allied Health Professions Federation Scotland): I represent the Allied Health Professions Federation, which includes 14 professional bodies and around 14,000 staff around Scotland.

There are significant recruitment challenges in remote and rural areas. In some areas, 35 per cent of staff are due to retire in the next five to seven years and up to 20 per cent of posts are vacant. What concerns us particularly is that, even when new graduates apply for posts, they stay for

a very short duration and tend to leave after two years. They use the post as a stepping stone to get some experience, then go and work elsewhere.

That happens for two reasons. First, practitioners require more generalist skills to work in rural areas, which sometimes seems less attractive to staff. Secondly, there is less career progression in remote and rural areas. There is no way for remote and rural areas to incentivise people to come and work in those areas and then to stay there.

People need to travel to different locations to deliver care. That is very expensive for staff. There is also the difficulty of getting affordable housing. We have had stories about people applying—

Sandesh Gulhane: Sorry—my colleagues will come in on the theme of travel, housing and other things. Will you focus a bit more on the contract and the difficulty in getting the numbers that you need?

Sharon Wiener-Ogilvie: We are seeing reduced numbers of AHPs coming out from universities. Although there are Scottish students, fewer graduates are applying for the posts.

We feel that there are solutions, including grow-your-own-workforce initiatives such as earn and learn. However, to do that, we need the universities to deliver training to allied health professionals in a flexible way. Online training needs to be delivered remotely and the academic curriculum needs to be condensed so that it is delivered, for example, over three days, not five, with the AHP undertaking two days' practical work in their host health board. That way, we can recruit people from remote and rural areas who very much want and need jobs in those areas, and they will not have to relocate to the central belt to do their training, which is very costly. I think that there is appetite from boards to deliver such solutions but, at the moment, the universities do not provide the hybrid learning that would allow us to provide those opportunities.

Sandesh Gulhane: Thank you. I do not know whether anyone else wants to come in before I ask my next question.

Derek Laidler (Chartered Society of Physiotherapy): In many remote and rural areas, some of your GP colleagues did not welcome the contract with open arms. From a physiotherapy point of view, we typically put in place high-band posts that are quite attractive, so recruitment into those posts has not been that difficult. However, we created between 200 and 250 new band 7 posts and where we recruited to them internally, a huge void has been left behind in mainstream services. That has been more of an issue.

I will give you an example from NHS Highland, where I work. In the north area of north Highland, we cover every GP practice with a first-contact practitioner. That has a huge impact in allowing people to access specialist MSK knowledge close to home and is of huge value. However, there will always be an undercurrent if the GPs are unhappy with the contract. They will not particularly want to see the model as successful, and any issues that might arise will be picked up.

Moving to another part of NHS Highland, in Argyll and Bute we cover 16 out of 31 practices, which is actually 86 per cent of the population, but there is still a cry of inequity. The cry is not just about inequity; it uses that situation as an example that the new GP contract is never going to work.

We have worked really hard to deliver on the contract and, from the Chartered Society of Physiotherapy point of view, we absolutely welcome it. Having those first-contact practitioners in local areas for communities has been successful and is working well, but we have to understand the wider context of accepting the contract or disagreeing with it fundamentally. From a physiotherapy point of view, we absolutely see the value of it and have worked very hard to deliver it.

There are also other models. We are trialling an electronic access and self-management plan to sit alongside our first-contact practitioners, which will help to provide additional cover for those people that do not need to see somebody face to face. There are other options and developments that we can work on.

The biggest void has been from taking that huge number of very experienced physios out of mainstream services and putting them into GP practices with nothing following behind. As Sharon Wiener-Ogilvie has said—I am sure that we will get a chance to discuss this at some point—the number of AHPs, particularly physiotherapists, being trained and coming through into the service is quite worrying.

Sandesh Gulhane: I certainly think that my colleagues will pick up on that, so we will not delve into it just yet. You talked about inequity, which I want to come to.

I think that physio is slightly more unique, because you have gone from centralised to local services. I think that a lot of the worry is the opposite way, about local things becoming centralised.

That brings us to the question of inequality. One respondent said that AHPs should be

"equally shared in all practices".

They used Caithness as an example:

"some ... first contact services are mostly in the NHS managed practices so not equally shared with other or rural practices so patients"

are

"unable to have equal access for care."

Is there inequality? Clearly, for physios, that does not seem quite to be the case, but are there inequalities when it comes to other allied health professionals, especially looking at vaccinations?

Neil Carnegie (Royal College of Occupational Therapists): From an occupational therapy perspective, there are pockets of good practice across Scotland where occupational therapists are employed in primary care, but it is very patchy.

For example, in Lanarkshire recently, they recruited to something like 36 posts, so that every GP practice would have an occupational therapist attached to it. That was after successful pilot projects that showed that having occupational therapists in primary care reduced the burden on GPs. The number of referrals that GPs had to deal with was reduced by literally hundreds, which took a lot of pressure off the system.

There are also good examples outside of Lanarkshire. In Ayrshire, they have managed to recruit quite a few. However, in Fife, where I am from, there is not a single occupational therapist in primary care. My understanding is that, throughout Scotland, it is perhaps unusual to have none, but very few areas have gone down the route of Lanarkshire.

I have spoken directly to GPs and have seen GP tributes. In Lanarkshire, for example, they spoke to the GPs and recorded videos of them speaking incredibly favourably of what occupational therapy brings to primary care—the difference that it makes and how much stress it alleviates from the GPs themselves. I have shared that with some of our local GPs. One of them, Dr Glyn McCrickard, said to me that it seems like a no-brainer, and that that is what we should have, but it is not included in the contract that Fife or anywhere else has to go down that route.

Out there, the GPs who are in the know recognise occupational therapists. The GPs in Lanarkshire described us as being general practitioners. They said that we bring something unique in our holistic approach and that we deal with people's physical difficulties as well as their mental health issues. Unfortunately, as I said, there is nothing to say that primary care has to employ occupational therapists so provision is incredibly patchy, although there are great examples out there of the difference that occupational therapy can make. That is the position that we are in.

Catherine Shaw (NHS Highland): Good morning. I echo what the first speaker said, which is that we are very much governed by, and at the mercy of, the academic year. That situation is not particularly friendly when we look to take on staff and educate them to the level that we need. Sometimes, we have to wait for up to a year for that academic year to come round again, so that we can get them on to courses.

I manage a team of advanced nurse and paramedic practitioners who are scattered across the west Highlands, but we have teams all across the Highlands. That has been incredibly successful. We started it more than seven years ago. Although there was a little pushback at the beginning from some staff and from some communities, it allows us to deliver care to islands on which we could not deliver it before, and to very remote and rural areas.

I think the problem in remote and rural areas is that we have small pools of staff and we are spreading them very thinly. When we want to take on staff and educate them to a higher level, we take them from the same pool, which obviously puts pressure on some hospitals and GP practices. We need to look at how we can manage that safely while still allowing staff to be able to study and work at a higher level.

09:30

Sharon Wiener-Ogilvie: I think that there is quite a mixed picture on inequality. In the Borders, for example, we have just one or two health board practices. The first contact practitioners are in the general practices—so it is as though they are everywhere. The issue is with the really remote and rural areas where the GP practices are quite small, so it may be less cost effective for them to have allied health professionals and it is very difficult to recruit them to work in those areas as part of the multidisciplinary teams. If we expand beyond physiotherapists and look at England, the model is to have podiatrists and OTs—the OT model has a good evaluation for staff satisfaction as well as impact. There are challenges with replicating that model in remote and rural areas because of the workforce issues that we are having.

Sandesh Gulhane: That was my last question. For the record, I have worked in Ayr and recently did some shifts in Fife. I have also worked in the central belt. When I can work with allied health professionals—it does not matter who they are—it is amazing; my life is so much easier. In contrast, when I go to shifts where there are no AHPs, such as the one that I did in Fife, my shifts are so much harder. It is a difficult thing.

Derek Laidler: I will come in with one more point. You mentioned a GP in Caithness who said that they felt that access was inequitable. You also mentioned vaccinations and community treatment and care—CTAC—services. I have noticed that the pushback from practices that are not supportive of the contract really ramped up when the CTAC services were introduced. Those were possibly the first of the primary care workstreams to be excluded from practices. However, since that happened, we have seen a number of examples of GPs—not just those that did not want to accommodate the AHP services in the first place, but those that had an established FCP service—that have now turned around and said, "We will not host them in our practice any more. You will have to find alternative accommodation. You will have to find alternative services." It is almost as though those services are being used as a football to demonstrate their dissatisfaction with the GP contract.

At times, there are issues with finding accommodation, but even where we have had that, we are starting to find that there is a little bit of pushback. Some of the surgeries are now actively exploring whether they can have the primary care workstream staff removed from their practices and what that would look like. For one practice, the only alternative accommodation that we have been able to find is 10 miles away. Instead of us trying to get closer to the patients, we are having to go further away, as well as further away from the main physiotherapy services. However, that is the only alternative that we have to provide the service that we are committed to providing. It is not just a case of us picking and choosing where we put those services. We have to work in collaboration with our GP colleagues. When there is a level of dissatisfaction with the overall contract, that can become quite difficult.

The Convener: Emma Harper has a brief supplementary.

Emma Harper (South Scotland) (SNP): Thanks, convener. Good morning to you all. I have a brief supplementary for Neil Carnegie. You talked about pockets of good practice. I know that we have heard from the CEO of NHS Borders, Ralph Roberts, about prehab and also reablement. Is that part of good practice? Can you give us an example of what OTs can contribute on the ground that makes a difference?

Neil Carnegie: Occupational therapy is fairly unique in its holistic approach. When occupational therapists are involved in primary care, we take an early intervention approach and we look at every aspect of a human's life. Occupational therapists look at not only a person's medical conditions or psychological issues, but their social issues and their housing. That unique approach makes a difference.

Recently, I have done a lot of research on the link between ill health and unsuitable housing, and the impact that that can have. If someone's house is not suitable, it may result in them having falls at home, especially if they are disabled, and it can also affect hospital discharges.

Occupational therapists in the community play a big role in ensuring that people's homes are suitable and safe and promote their independence. If a person is living in a home that is suitable for them and that enables them to carry out the activities of daily living that they need to do for self-care, every single day, it lifts a huge burden on paid and unpaid carers. It prevents people from going into hospital and prevents them from needing to go into residential care too soon or at all. That may give a little flavour of the difference that occupational therapists can make.

We also support people's mental health. What we do is not just about providing physical support or adapting people's environments, it is about looking at every aspect of a person's life. That is where we make a unique difference and it is our unique offering.

Gillian Mackay (Central Scotland) (Green): Good morning. For each of your disciplines, what are the specific challenges of working in a remote and rural area in relation to providing both routine care and specialist care for less frequently encountered conditions?

Derek Laidler: That is a big issue for physiotherapy. There is a bit of a misconception that we have generalist physiotherapists in remote and rural areas who can provide specialist input into absolutely everything. That is just not the case. When putting a team together in a remote and rural area, the biggest and hardest job is ensuring that there are specialist skills available in the team. Health boards that cover remote and rural areas often have only one or two highly skilled specialists, but they could be as far as 200 or 300 miles away. That is not really an accessible service, so we need to ensure that specialist skills are available.

A good example of that relates to neurology services. If a person has had a stroke or if they have multiple sclerosis—we have a very high number of MS patients in our remote and rural areas—they need specialist input. They do not need input from a generalist who can nibble around the edges of their problems; they need someone with in-depth knowledge and skills who can fix those problems. However, there is not always understanding among health boards that that is what is required. There is an assumption

that physiotherapists can morph and have a range of specialist skills, but we absolutely cannot.

Our undergraduate training is general, and developing specialist skills takes a number of years of experience and postgraduate training. If a person does not have that, they cannot effectively support some of our patients with complex needs. It is right that a lot of the work is quite generic, and we can manage that with generalist teams, but that is not going to cut it for someone in a remote and rural area who has had a stroke. We need to have the space, time and opportunity to provide that training to staff.

We see exactly the same type of patients who are seen in big central belt hospitals, but there are fewer of them. That leads to a problem in how we maintain specialist skills. It is a challenge, but we work hard to ensure that we have appropriate skills in place.

Sharon Wiener-Ogilvie: Even in areas where we have some specialists, they are often sole practitioners, so if they are sick, there is no access to practitioners. If they are in a specific area covered by a rural health board, that is a real issue.

Gillian Mackay asked about routine care. We find that because allied health professionals now have to focus on getting patients who are very sick and in hospital back home, we are diverting resources from our preventative services. We are not tackling the issue further up the line, before people become acutely ill. In my podiatry service, I need to divert my workforce to focus on acute cases, such as those involving treating foot or leg ulcers, to save limbs. I cannot divert my workforce to do the prevention work that would prevent people from getting on the slippery slope that they are on. That is a real issue for all allied health professionals because of workforce challenges and the acute nature of patients' need, following Covid.

Neil Carnegie: I echo what Sharon Wiener-Ogilvie said. We should focus more resource on early intervention and prevention, and on trying to stop that cycle. Unfortunately, we have to divert too much resource to meeting critical priorities, where people are at the highest risk. A lot of resource goes towards facilities and hospital discharges.

Recruitment and retention issues accentuate the situation. As Derek Laidler and Sharon Wiener-Ogilvie alluded to, that is particularly the case in a lot of rural areas. The cost of housing can make it difficult to attract and retain staff, because they just cannot afford to live in those areas. That is mainly because prices have been pushed up by tourists and because a lot of people own second homes.

We will probably come on to this, but one solution that we really need to push forward is training people who already live and are embedded in a locality and who are not going to go elsewhere. We need to utilise opportunities such as earn as you learn and apprenticeships to try to solve recruitment and retention issues. Those issues will only get worse. Sharon Wiener-Ogilvie quoted some stats earlier. We have an ageing workforce and, in the past few years—probably accentuated by Covid—a lot of people have left the allied health professions. Not enough students are coming through, which is exacerbating the issue. If we do not take action and do things differently, the situation will only get worse.

Gillian Mackay: A couple of you said that, quite often, workers are lone workers. They are often out in the community or working in quite small general practices, and they might be th\e only representative of their profession in a multidisciplinary team. Are we properly supporting those individuals at the moment?

Derek Laidler, I will come to you first, because you shook your head. If we are not supporting those individuals at the moment, what needs to be put in place to support them and help them to develop the skills that there are in other health boards in which some of the training, learning and support pathways are taken for granted?

Derek Laidler: Yes, we do take that for granted. Again, I can speak only for physiotherapists. Most physiotherapists go into the profession to be clinicians. Given the chance, they will see patients morning, noon and night. The value that they and their employers put on their non-clinical time is not always as it should be. There are no Scottish guidelines on how much time should be dedicated to non-clinical time and training. That is left to clinicians.

09:45

When I have managed teams, I have tried to include non-clinical time. At one point, we had a big diary—it was almost like a hairdresser's diary—for one of my teams, and we used that as a patient diary. I would use different colours to mark the team's non-clinical time, but they would just write in patients. When I then made the spaces black, they would just stick little white labels on and fill them in with patients.

Long waiting lists and queues of patients put pressure on clinicians, particularly in remote and rural areas. If you are, say, the only physiotherapist in an area and you have a huge waiting list, you feel that it is all on you. As a result, we need some way of legislating for this and saying, "Okay, this is your clinical time, but

this is your non-clinical time, because it's important for developing not only yourself but the services." That would be really useful.

Everything is being cut to the bone. I cannot count the number of times that we have been asked to try to recruit people for part-time posts—or there might just be one post—in remote and rural areas because that is all the funding that is available. The establishment funding might not have been reviewed for 20 years, and there has never—at least until next April—been a mechanism to match capacity with demand. I welcome the staffing legislation that is coming in, as it will allow us to start to do that, but the fact is that it is unlikely that we will recruit to part-time or very isolated posts.

At some point, there will need to be a little bit of acceptance of that situation. When we went through a workforce establishment process, we found that, in our remote and rural communities, up to 50 per cent of our community physiotherapists' time was spent driving around and between places. However, when you looked at the actual workload, you would have said that we needed one whole-time equivalent, so that is what we would employ. However, we got only 50 per cent of their clinical time, as that other element was not considered.

Lots of considerations in rural areas are not taken into account, and I sincerely hope that the staffing legislation next year will help us to address that, as we will be able to articulate it better. From the clinicians' point of view, however, we need some guidelines that say, "Okay—this is what we expect of you with regard to your clinical contact, but non-clinical contact time is equally important."

The Convener: I see that Catherine Shaw wants to come in, but I am conscious that we are already half an hour into this session and we still have lots of questions, so if witnesses could be concise with their answers, that would be very helpful.

Catherine Shaw: Our biggest challenge is the fragility of the teams. Very remote and rural areas have very small teams, and it does not take much to destabilise things. Members of the team that I manage work out of hours in remote and rural areas, so they work in isolation and therefore require a good degree of resilience and generalist knowledge.

Our biggest problem is that fragility. We keep being asked to carry out establishment reviews, but when we do, we find that footfall indicates that we need only one person. For the service to be supported, however, it is likely that we need more than one. It is exactly as Derek Laidler suggested: we do not take into account the need for support, the need to travel and so on.

Carol Mochan (South Scotland) (Lab): I am very interested in the notion suggested in the evidence of trying to recruit people from the area. Indeed, I have had some discussions with NHS Education for Scotland on that. If you were to give us one or two pieces of advice, could you tell us, first, what the stumbling block might be? Since I have been elected, I have been asking how we move forward and I cannot find out what the stumbling block is in that respect.

Sharon Wiener-Ogilvie: It is the universities.

Carol Mochan: Okay.

Neil Carnegie: It is funding, too, though, isn't it? My understanding is that, in England, where these courses have been in place for a number of years, the funding is ring fenced. You would need to check the accuracy of this, but my understanding is that, although in England the money was ring fenced, the money that came to Scotland was not. I think that the funding might have been calculated through the Barnett formula and that what came here just went into a general pot because it was not ring fenced.

We would need to have a similar arrangement in Scotland in which funding was in place, because universities will not run the courses unless that funding is available for them.

Sharon Wiener-Ogilvie: In England, money from the apprenticeship levy is given back to boards, which can then develop their own apprenticeship programmes. In Scotland, money from the levy goes to Skills Development Scotland. There are political decisions around that, which I will put aside. Currently, the real issue for us is that a lot of our boards are sitting with underspends. I am sitting on a £300,000 underspend. I have the money to develop earn-as-you-learn initiatives, but I cannot do that because universities will not deliver the learning online and will not condense things into three days a week.

Only three universities in Scotland deliver allied health professional training, and two of them are in the central belt. That was of no help to me when I was a manager in the Borders, and it is of no help to my colleagues who are managers in Dumfries and Galloway, because people cannot travel for three hours and afford not to work and so on. Pressure needs to be put on universities to transform the way in which they deliver training. That is the stumbling block.

Derek Laidler: I will try to keep it very brief and give you two pieces of advice. First, we have talked a lot about the apprenticeship scheme. We have a lot of very good physiotherapy assistants and technical instructors embedded in our teams and our communities. We do not have to worry about housing for them or about them moving on. In NHS Highland, we have 14 technical instructors

who want to be physiotherapists, but they have no route to do that.

Sheffield Hallam University has a 27-month programme to take very experienced technical instructors and assistants to qualified status. If we followed its example, in that time, we could have 14 new physiotherapists who are already embedded and working in our teams in NHS Highland. That would be transformational.

Secondly, our masters programme is now more popular than the bachelors honours degree route. Despite Edinburgh Napier University coming online and having very few overseas students, about 60 per cent of students—the figure has been as high as 80 per cent—on masters degrees are overseas students, many of who come from Canada. Eighty per cent of the students going through the masters programme will go back to Canada. We are doing a brilliant job at training Canada's physiotherapy workforce, but we cannot find staff for our own areas.

Therefore, my two pleas are to use the earn-as-you-learn and part-time study apprenticeship model and to fill our courses with United Kingdom-based staff. Having both those things would be brilliant.

Ruth Maguire (Cunninghame South) (SNP): Carol Mochan has read my mind—that was exactly what I was interested in asking, and the witnesses have answered it fully.

The Convener: We will move to Tess White, who joins us remotely.

Tess White (North East Scotland) (Con): I will follow up on the funding question to Sharon Wiener-Ogilvie. You previously told the committee that short-term funding and lateness of funding were issues because the money was not getting to the boards and that those aspects negatively affect recruitment and retention of staff. Is that still the case or have those issues gone away?

Sharon Wiener-Ogilvie: Did I say that just now?

Tess White: No, I think that you said it in 2021.

Sharon Wiener-Ogilvie: Okay; right—that was in relation to another inquiry.

I cannot answer that question at the moment, unfortunately. I am not experiencing that in the board that I am currently working in. Without looking into the details and checking with other boards, I cannot give you the answer to that.

Tess White: That is fine; that is an answer in itself. Thank you.

My second question is to all the panel members. The Scottish Government published a national workforce strategy for health and social care and a workforce policy review for allied health professionals but, as we have established, neither of those covers rural or remote areas. A strategy on that is due to be published by the end of next year, in 2024. Given that a one-size-fits-all approach to NHS workforce planning clearly is not working for rural areas, should that strategy have been published sooner? What should be included in it?

I ask Derek Laidler to answer first, because he talked about needing to take rural considerations into account.

Derek Laidler: If I can very briefly go back to your previous question for Sharon Wiener-Ogilvie, I confirm that the impact of delayed funding or short-term funding is a real issue. We have a good example in Argyll and Bute, where an AHP-led active clinical referral triage process is reducing the number of patients who are being referred to orthopaedic services by 60 per cent. That process had to run from April until last week with no funding whatsoever, because the waiting list initiative funding that was supposed to be issued in April did not come to our board until last week. Therefore, there are still impacts such as that—really good projects are at risk of falling apart because the funding is delayed.

Going back to the question of what the considerations are, I articulated, as best I could, that we did a mock-up of the workforce establishment process in preparation for the staffing legislation, which gave us clear indications of what our remote and rural physiotherapists are doing with their time. A lot of it—up to 50 per cent—was travel.

The administration and information technology support is not always in place to support lean working in remote and rural areas, and then there are the big issues of fragility and sustainability. If you have one practitioner who is providing those services, and that one practitioner is off, there is no service. In central belt areas or other more densely populated areas, that might put pressure on the rest of the team, but there will be some on-going service. We have to be aware of that aspect for remote and rural areas.

We also need to bear in mind that the vacancy factor that is built into nursing budgets is not built into AHP budgets—there is no AHP factor. Therefore, if you hire one physiotherapist, they are there for 42 weeks a year, and you already have a number of weeks when there is no service. If we want a sustainable service for 52 weeks, which does not disappear when one person is off sick, we need to find a way to factor that in.

Sharon Wiener-Ogilvie: I will come back to Tess White's earlier question, because I now

remember what it was about. You caught me a bit off guard.

One area where we have significant issues with short-term funding across Scotland is nutrition and dietetic weight management. That funding is always short term, and we find it difficult to recruit into those short-term contracts. We cannot fill those posts, because they are short term and there are not enough dieticians to pick up those posts. There is often a significant underspend. The issue is broader and does not just affect remote and rural areas—I know that it exists in the Borders, Fife and many other areas, unfortunately.

Tess White: That is helpful. Before I pass back to the convener, I will go back to the question of what should be included in the strategy. Catherine, if you could give a view on that, that would be helpful.

10:00

Catherine Shaw: It needs to be recognised that delivering as equitable a service as we can in remote and rural areas is incredibly expensive. Without investment in the service, we will not be able to do that. We are very fragile and have small teams. We are trying to bring in people, but it takes a long time to train them. If somebody with experience leaves, we have a month to fill that post and we generally have to go outside to bring somebody in, because we are not investing in our services at the moment.

Tess White: Are you suggesting that you almost have to overstaff in rural areas?

Catherine Shaw: Yes, I believe that we do. We have to recognise that there are times when we have to be proactive and not just react to any given situation, because that puts pressure on communities and on the staff who are left behind. It means that we are busy chasing up everything and trying to fill the gaps—if we can—with other staff, which puts pressure on them. In some areas, we need to be proactive and to overfund and overstaff.

Tess White: Thank you.

Emma Harper: I am interested in continuing professional development. I think that one of the witnesses has already alluded to the importance of it. The committee has taken evidence on the clinical skills managed educational network, and we have heard about the mobile skills unit that goes out to rural areas to provide simulation training and so on. I am interested in your thoughts on the requirements to value education. I say that as a former clinical educator, and I am still a registered nurse. My job was to work with allied health professionals and nurses in teaching clinical skills across NHS Dumfries and Galloway. What needs to be valued when it comes to continuing professional development?

Derek Laidler: It is vital that all AHP staff are registered and regulated and that they undertake continuing professional development. However, as I said, that becomes difficult when you feel the pressure of waiting lists and there is little understanding in health boards of the continuing professional development needs of AHPs. Training budgets have pretty much disappeared so, in most cases, we have no such funding in our budgets. I have become very good at finding alternative sources of funding, which I will continue to do, but there is almost an acceptance that there is no money.

We have made huge leaps forward in being able to accomplish training online, which is really welcome, particularly in remote and rural areas but, if we do not have the budget even to pay for online training, it becomes very difficult. Training budgets are low-hanging fruit—they are easy to remove, and that has happened consistently across AHP budgets.

Emma Harper: I will pick up on what Sharon Wiener-Ogilvie said about travelling a great distance to engage in education, whether it is paramedic training or other skills learning. I am aware of a reduction in relation to spirometry. That can be delivered by nurses, GPs and physios, but the quality and outcomes framework reduced the spirometry payments for general practices, so it is now not conducted there. That means that, in remote and rural settings, there will be a reduced ability to assess whether someone needs a chronic obstructive pulmonary disease or asthma diagnosis. That is just one issue that has come up. What is NES's role in supporting education and continuing professional development?

Neil Carnegie: Occupational therapy is unique among the allied health professions, in that it is the only one that spans both health and social care. I find that conversations such as this one often overlook the fact that occupational therapists are employed not only in the NHS but by local authorities. NES does a lot of very valuable development work, but someone who is employed by a local authority, as I am, often finds that that is very much delivered within the health service. When we have such conversations, it is often forgotten that local authorities also have a responsibility to support the continuous professional development of their occupational therapy staff. Any initiatives always go through NES, but do not necessarily make their way to local authorities.

In some joint boards such as the one in Fife, there is really good work on relationships and good integration. My staff could go on to Turas to access training that NES has developed, but that

is pretty patchy and I am not sure that that practice is consistent across the country. In these conversations, it is important that we remember that we are talking not only about the health service and NES and that we have to think about the many local authority OT staff.

Derek Laidler made a point about the pressure on staff, which is also felt in local authorities. Training budgets are very small, as Derek highlighted. To maintain their registration to practice, all AHPs have to give evidence of continuing professional development. They can be asked, on a two-year cycle, to present that evidence and cannot maintain their registration otherwise. Training budgets are under pressure, as are staff. When there are hundreds of people who are waiting to be seen, some of whom might have been waiting for a year, depending on the area, staff feel that pressure. Even if you give them permission to take time out to do some continuing professional development, they feel the pressure and a responsibility. They have come into a caring profession because they want to help people, so the first thing that they often choose to do, as Derek highlighted, is to give up the training time so that they can see another patient.

Emma Harper: You mentioned Turas digital training. I am familiar with that and know that it is valuable for some things, but face-to-face training is also valuable.

You made the point that integration means that work is patchy. You said that OTs are employed by local authorities. That probably needs to be investigated, so that the silo approach doesnae happen.

Neil Carnegie: Derek Laidler spoke about the safer staffing legislation, which covers the NHS and social care settings. Occupational therapists in the NHS are specifically covered by that legislation, but the legislation, and the guidance behind it, fail to recognise that occupational therapists work for integration joint boards and in integrated teams and services, which have a mixture of local authority and NHS occupational therapists. That is quite problematic. If you are trying to safeguard staff and the delivery of services, how can you do that in integrated services if you include only a percentage of your occupational therapists?

Emma Harper: I was going to ask about the numbers of OTs who are employed by local authorities and by the NHS, but we can get that information later.

The Convener: Perhaps Mr Carnegie could write to us about that.

Neil Carnegie: I do not have those figures. In fact, I was speaking to the Royal College of Occupational Therapists board to see whether anybody held them, but we do not have them.

You could, for example, go on to Turas and get the national figures for NHS OT staffing, but local authorities are separate and there is no similar arrangement for them to easily get that information.

Emma Harper: Okay, thanks.

Derek Laidler: Could I possibly—

The Convener: I am sorry, but we need to move on to questions from David Torrance.

David Torrance (Kirkcaldy) (SNP): Good morning to the panel members. Some of you touched on these issues earlier, but can you expand on what infrastructure improvements would encourage people to apply for posts in remote and rural areas?

Neil Carnegie: We have all spoken about the big change maker, which is earn-as-you-learn opportunities for existing staff. Within our staffing groups, we could all pinpoint the huge appetite among technical instructors or assistants, who would love to have that opportunity of career progression. Those are staff who will stay in the area because they have families, homes and lives there. For me, that would make the biggest difference but, even if that is introduced, as Sharon Wiener-Ogilvie alluded to, there has to be the opportunity for that to be done through distance learning.

Sharon Wiener-Ogilvie: There are a few issues. For me, there is something around compensation for travel costs. A lot of the time, the distances that people have to travel are costly for them. Housing is also a huge issue. I had staff who tried to move to the area but could not find housing, so could not take the jobs. That is a real issue, so we need incentives around travel and housing.

The other thing is IT; patchy internet not only makes it less attractive for people to move into the area but impacts on our ability to deliver services to people in a more innovative way. It is about internet coverage in rural areas and the appetite around the risk of implementing innovative solutions that use information technology. Different health boards have very different appetites for risk, and some of the rural health boards are quite risk averse. In some health boards, models that use information technology are being developed, while other boards are going nowhere near it, so there are discrepancies that might be to do with health boards' IT infrastructure.

David Torrance: Sharon Wiener-Ogilvie mentioned growing your own workforce. What impact is depopulation in remote and rural areas having on the ability to get that workforce?

Derek Laidler: I do not find that to be a huge issue. The population is ageing, but the pandemic showed a lot of people that there is huge value to living in remote and rural areas when it comes to bringing up children.

Housing issues are the biggest barrier to repopulation. We are building new housing stock but, if half of it is empty throughout the winter months, it is of no value whatsoever. People are willing to move to those areas, but they need to feel connected.

That goes back to the question about what we can do to facilitate people. They need to feel connected, whether that is professionally—with systems that allow them to work easily and freely in remote and rural areas—or whether that is having suitable housing to move into.

Undoubtedly, the population is ageing, and we need to encourage people to move to remote and rural areas, but there is certainly a desire for that. The problem is that people who can afford to do so are doing so in the summer, in second homes.

Sharon Wiener-Ogilvie: For some non-registered posts, such as healthcare support workers, we get up to 30 applicants, so we know that we have people whom we can develop. It is the registered staff that we cannot get, but we have signs that we would have people to train if we had those opportunities.

10:15

Sandesh Gulhane: We are hearing a lot about wider infrastructure issues, and we have heard a lot about incentives. My question relates to the work of Dr Gordon Baird in Galloway. Do you feel that having a rural and remote advocacy service would be helpful in ensuring equality as well as in holding boards and other areas to account, so that things are in place to allow people to go and work in rural and remote areas?

Derek Laidler: Certainly, that would be helpful, even with regard to the funding for rehabilitation services, which predominantly involve the AHP workforce. That funding is not always used for that purpose by the health boards. I think that there was one health board where not a penny of the integrated care funding was spent—it just went towards savings.

As the funding is not ring fenced, it would be incredibly useful if boards were held to account for delivering it to the services for which it is intended. It is frustrating that there is a willingness on the part of the Government to provide the funding but, by the time it gets down to the health boards, it is diverted to putting out fires elsewhere.

Ivan McKee (Glasgow Provan) (SNP): The Government and NHS Education for Scotland have launched the national centre for remote and rural health and care. What is your understanding of how that the centre will operate and what its priorities will be? Will it be focused on the right kinds of things, given the wide range of issues that we have already talked about?

Derek Laidler: I work with NES quite a lot on a variety of areas, and what always strikes me is the need for a lot more connection between NES and clinicians. There seems to be involvement from NES at a higher level, but it would be lovely to see the priorities being driven by clinicians in remote and rural areas through a bottom-up approach rather than the top-down approach that it appears sometimes happens with NES.

Ivan McKee: Is there a sense that, now that the national centre has been put together, its structure and priorities do not necessarily reflect what you were expecting?

Derek Laidler: Yes. We need NES to meld those Government national strategic priorities for remote and rural areas with the reality of clinical provision on the ground. That is very much where I feel that NES could be incredibly useful.

Ivan McKee: Are there any specific examples that you would like to highlight?

Derek Laidler: I have done some work on a variety of projects in relation to frailty and falls, but that is because I have stuck my nose in rather than because someone has come looking for an opinion. Again, we have lots of pockets of good work on the ground, but they are not necessarily even known to NES teams.

I would like to see greater engagement. I would like to see a level of what might almost be described as outreach, with NES going around hospitals and rural areas and asking, “What do you need from us? We have these overarching strategic priorities that we have to address, but how can we help you do that in a remote and rural area?” We welcome the setting up of a remote and rural centre, because, as we have already discussed, one size does not fit all when it comes to healthcare across Scotland. The priorities in the central belt and those in rural areas are very different.

Sharon Wiener-Ogilvie: What slightly worries me is that we have seen a hell of a lot of strategies going around; we had the workforce development strategy for AHPs and now you are talking about another strategy for remote and rural areas. What we are not seeing are implementation plans, and those are what will make the difference. We do not need just another strategy; we need implementation plans around that strategy and, as Derek Laidler has said, we need to involve staff, too.

As for the other question about courses and what NES can do, there is a role for generic courses, but they can never take away the need for hands-on, practical courses that allow advanced practitioners to develop and support GP practices, rehabilitation services and prevention approaches. There is a limit to what NES can offer on some of the courses—for example, it cannot deliver courses on joint injections or ultrasound scanning or other specific courses that we need—but it can play a role in helping us support boards to develop work plans so that staff can do their workforce planning.

Catherine Shaw: I want to sound a positive note about remote and rural education. There is a new course in the University of Highlands and Islands—the rural advanced practice MSc—that is open to all advanced practitioners. That course, which started in September, has been a number of years in the making, and people in remote and rural areas were spoken to about it before it started; indeed, staff from the university spoke to me and members of my team on a number of occasions before they developed the course.

We are all keeping our fingers crossed for it. It is a rural advanced practice course, not a rural nurse advanced practice course, and we are keeping our fingers crossed that it will focus more on the issues faced by those in rural areas and on the training that people require to work in the more rural areas.

Tess White: I represent the North East Scotland region, where the challenges of delivering remote and rural healthcare can be acute, especially with regard to recruitment and retention. I have highlighted Braemar in Deeside a couple of times now as an example of an area where they have been unable to recruit a GP, despite a huge community-wide effort to do so. I understand that the practice is due to hand back its contract to NHS Grampian today. We know that housing is a big issue in this respect, but what other infrastructure improvements would you welcome in such areas? That question is for Catherine Shaw.

Catherine Shaw: Most people come to live in remote and rural areas for lifestyle reasons, so we need to look at the schools and childcare. Indeed, childcare is an enormous issue; people might well want to come up to work, but when they do, they cannot find anybody to look after their children. We also need to consider work for partners, too.

Career progression is a massive issue; people come up and we cannot keep them because there is a glass ceiling on where they can go. In the hospitals on Skye, for example, we have one band 7 post, which would mean that a nurse who came in to work at band 5 level on the wards would, in reality, need to leave if they wanted to progress in their career. They would not necessarily have to leave the area, but they would certainly have to leave where they were.

Therefore, we need to look at career progression, childcare and, indeed, housing, which is another massive issue and is related, again, to affordability. I have to say, though, that Lochalsh and Skye Housing Association is doing a sterling job of trying to support us, and the community tries to support us, too. However, we do need to consider housing and childcare.

Tess White: I have two, quick follow-up questions. I noticed that, in an article from 2019, you highlighted that ANPs in rural support teams cannot use green-light vehicles to speed up travel time in order to see sick patients. Is that still the case, and if so, how has it affected response times?

Catherine Shaw: It has had a massive effect. I constantly get the argument that, even when they see the blue light, people do not pull over. There will always be people who do not do that, but the fact is that the areas in which these staff work are generally tourist areas, so in the summer, it is impossible to move in traffic. If staff are told, “Flash your lights and beep your horn” and they do so, people just think that they are being bullies and get combative. As a result, staff will not do that. It seems ridiculous, though, that you cannot put a green light on the car unless you are registered with the General Medical Council.

Tess White: Finally, in the same article, you mentioned a nurse who had hit a deer with a vehicle. Could you share your team’s experience of using their own vehicles in remote and rural areas as far as accessibility and cost are concerned?

Catherine Shaw: Because of the difficulties in remote and rural areas, we try—or have tried—to bring in vehicles for staff. After all, they need to carry an awful lot of equipment, and the weather can be incredibly bad. However, that has proved to be difficult with some of the new legislation, because of costs and such things, so more and more staff are having to use their own vehicles, and more and more staff are not wanting to do so. The fuel allowance that they are allowed under agenda for change is just not sufficient to cover repairs that might be required, the petrol, and, because of the additional mileage, the loss of value in their vehicle when they come to sell it. The situation does have an impact; if an area does not have a vehicle, staff are less likely to want to go there.

Tess White: Thank you.

Ruth Maguire: Catherine Shaw, I want to follow up something that you said in response to Tess White. You talked about Lochalsh and Skye

Housing Association doing what it can to assist you. Were you talking about a housing allocations policy, perhaps involving a preference for key workers or those with a local connection? What specifically is the association doing to assist?

Catherine Shaw: We have been working closely with the association since Sir Lewis Ritchie's report came out. When anybody comes in, the first thing that they are advised to do is to contact the housing association in Skye and Lochalsh and say that they are coming to work for NHS Highland. I believe that they are then given points on the system; that does not necessarily take them to the top of the list, and it does not mean that they will be allocated housing.

That said, if we are likely to lose staff because of lack of housing, there are a number of things that the association will help us with. It might not necessarily provide housing association properties, but it might put us in touch with people in the community who, as far as it is aware, might be able to help us.

We do work closely with the association. Over the past six months, three new staff have joined the team that I manage. One of them is in a housing association property, and two of them, working together, found accommodation through the housing association and word of mouth.

Ruth Maguire: You might not know the answer to this next question but, if not, we can find it elsewhere. Do you know whether the housing association and the local authority have a common housing register in Highland?

Catherine Shaw: I am sorry, but I do not know that.

Ruth Maguire: That is fair enough—we will find that out.

Derek Laidler: I can respond to that with regard to Argyll and Bute. There is one housing list for Argyll and Bute; however, although they are building up to 900 new houses in Oban, anyone at the top of the housing list will be offered that housing, even if they are from, say, Helensburgh or Campbeltown. The housing associations have tried to help us, and they have said that healthcare workers will be given 15 points on the housing list, but it takes more than 50 points to be put at the top of it. They have offered mid-level rentable properties, too, but only two or three. Indeed, I think that, of those 900 houses that they are building, healthcare staff have secured 10.

The other issue around the infrastructure means that, even if there are two people per household, that will add 15 per cent to the population of Oban, but there is no additional medical practice and no additional resource for the hospital, the schools and all the other infrastructure in the area. It is great to opportunistically build a lot of housing to bring people into the area, but as you can imagine, if you have a common housing list covering an area as large as the one that NHS Highland covers, it will be difficult to target resources to support healthcare.

10:30

Ruth Maguire: We could probably look at that issue further. I believe that many public sector areas face the same issue with regard to housing.

Neil Carnegie: On recruitment and retention, there is an issue that is specific to local authority occupational therapists. You mentioned agenda for change, which has seen significant and welcome increases in pay for staff across the board. However, because the pay negotiations for occupational therapists who are employed by local authorities go through the Convention of Scottish Local Authorities, we have seen the development of a significant difference between the wages that NHS occupational therapists receive and the wages that are received by their local authority counterparts. That creates issues for recruitment to the local authority OT posts. As we have already said, there is a shortage of qualified staff, so it is difficult to attract people to a local authority post when they could be paid thousands of pounds more a year in an NHS post to work shoulder to shoulder in the same team.

I would also like to pick up on the issue of travel expenses.

Ruth Maguire: Before you do, I have a specific question on the pay issue. When we were talking about the importance of housing for health, the issue of aids and adaptations and the need to assess people's homes when they are moved out of hospital sprung to mind. That tends to be the sort of work that local authority occupational therapists are involved in, so is that where the impact of what you are talking about would be felt?

Neil Carnegie: Yes, that is where the division is. However, under integration, there are now a number of joint teams and joint services, so there could be a team with occupational therapists who are being managed by the same manager, are doing the same job and have similar conditions but are on different contracts. Some will be NHS OTs and some will be local authority OTs, and what it means is that some will be getting thousands of pounds more a year than others.

As for travel expenses, I cannot speak for all the local authorities, but I know that Fife Council pays only the basic 45p a mile that is specified by His Majesty's Revenue and Customs, whereas I think that the NHS pays 64p a mile.

Those issues make it all the more difficult for local authorities to attract staff. We are all fishing from the same pond, but currently the pay and conditions in the NHS are a lot more attractive. That exacerbates issues with waiting lists and waiting times and makes it harder to move towards a preventative model.

Because you mentioned it, I would like to pick up on—

The Convener: I am sorry, but we have run out of time—we have already gone over the time that we allowed for this item, and we have more committee business after this. I must ask you to be extremely brief.

Neil Carnegie: I will be brief.

Ruth Maguire mentioned equipment and adaptations. That area is too easy a target for too many local authorities looking to make savings, despite the fact that, in 2016, the point was made in the chamber of the Scottish Parliament about having a spend-to-save policy, given that every pound spent on equipment and adaptations equates to a £6 saving across health and social care. However, equipment and adaptations budgets across the country are still being slashed.

The Convener: Thanks for that.

At our meeting next week, we will continue our inquiry into healthcare in remote and rural areas, hearing from more representatives of the healthcare workforce.

That concludes the public part of our meeting.

10:34

Meeting continued in private until 11:38.

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

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