OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 19 April 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

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Tuesday 19 April 2022

CONTENTS

Col.

DECISION ON TAKING BUSINESS IN PRIVATE 1
"NHS IN SCOTLAND 2021" 2
HEALTH AND CARE BILL 28
SUBORDINATE LEGISLATION 32
Sports Grounds and Sporting Events (Designation) (Scotland) Amendment Order 2022 (SSI 2022/86) .. 32
National Health Service Pension Schemes (Scotland) Amendment Regulations 2022 (SSI 2022/100) ... 32
National Health Service (Charges to Overseas Visitors) (Scotland) Amendment Regulations 2022 (2022/114) 32

HEALTH, SOCIAL CARE AND SPORT COMMITTEE

14th Meeting 2022, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

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

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Sam Baker (Scottish Government)
Stephen Boyle (Auditor General for Scotland)
Derek Hoy (Audit Scotland)
Leigh Johnston (Audit Scotland)
Humza Yousaf (Cabinet Secretary for Health and Social Care)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 19 April 2022

[The Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Convener (Gillian Martin): Good morning and welcome. I have received no apologies from members who cannot attend today's meeting. We will take evidence on Audit Scotland's report "NHS in Scotland 2021". We have the Auditor General for Scotland and supporting officials with us.

Before we get to that, the first item on our agenda is to decide on whether to take items 5 and 6 in private and to hold our next meeting, on 26 April, in private. Do members agree?

Members *indicated agreement.*

"NHS in Scotland 2021"

09:30

The Convener: Our second agenda item is an evidence session on Audit Scotland's "NHS in Scotland 2021" report. I welcome Stephen Boyle, the Auditor General for Scotland. It is nice to have you here in person. Joining us online from Audit Scotland, supporting Mr Boyle, are Derek Hoy, audit manager, and Leigh Johnston, senior manager. I invite the Auditor General for Scotland to give a brief opening statement.

Stephen Boyle (Auditor General for Scotland): Thank you, convener, and good morning, committee. I am delighted to be with you.

My report on the national health service in Scotland for 2021 turns our attention to the recovery and remobilisation of NHS services, while acknowledging that the NHS remains under severe pressure that has been caused by the pandemic and the backlog of patients that has built up in the past two years. At the time of publication of our report, the NHS was on an emergency footing and the path of the pandemic remained unpredictable. It is fair to say that it is still unpredictable. The Scottish Government and the NHS are planning for recovery from the pandemic, but the scale of the backlog of patients will make that challenging.

The NHS must also reform: services were already being delivered unsustainably before the pandemic. The Scottish Government must, therefore, focus on transforming health and social care services to address the growing cost of the NHS, while also supporting its recovery from Covid-19. That will be very difficult because of the competing demands of the pandemic and the increasing number of other policy initiatives, including plans for a national care service.

The innovation that we have seen during the pandemic shows that positive change can happen quickly and effectively: that momentum must be maintained. The Scottish Government published its "NHS Recovery Plan 2021-2026" last year and is also developing within the Scottish Government a care and wellbeing portfolio that is expected to provide a strategic direction for reform. The Government must also involve the public in deciding how future services will be delivered.

Workforce availability and workforce wellbeing are now the most significant risks to successful reform. Staff wellbeing has been hugely affected by the pandemic and the NHS recovery plan makes ambitious commitments that place significant demands on a workforce that is already suffering from fatigue and is at risk of burnout. The recovery plan makes several commitments that

require significant growth in the NHS workforce, on top of existing staffing commitments. The new "National Workforce Strategy for Health and Social Care in Scotland" was published in March. It remains the case that it will be challenging to achieve what is in the plans to recruit staff. We know, and have previously reported, that the NHS has, historically, struggled to achieve all its staffing ambitions.

Finally, we highlight the uncertainty that surrounds the long-term financial position of the NHS in Scotland. Under the new care and wellbeing portfolio, the Scottish Government plans to bring financial, service and workforce planning together in one place. That has the potential to make the NHS more sustainable, but those plans are at an early stage. Financial sustainability is a key focus of the Scottish Government's long-standing commitment to transforming how health and social care services will be delivered together.

I am joined by my Audit Scotland colleagues Leigh Johnstone and Derek Hoy; we look forward to answering the committee's questions.

The Convener: You have outlined the main points that the report makes about the challenges that we know the NHS is facing, and about some of the learning from the pandemic. Can you be more specific? A lot of what you say in your report it is no surprise to any of us. We have been hearing about those challenges for the NHS since the committee convened—and well before that.

The NHS is still on an emergency footing in most places. Given that health boards are responsible for how they manage their boards locally, is there an opportunity relating to some of the reforms that are taking place at the national level? Could the health boards that you have identified as having particular challenges be brought into line with those that seem to be managing better?

Stephen Boyle: I will bring in Leigh Johnston in a moment, because she is one of the authors of the report and has looked at some aspects of how reform will be delivered in the NHS.

As you suggest, there is not a uniform picture across Scotland. Through Audit Scotland's reporting over many years, we have produced statutory section 22 reports on a number of health boards, highlighting some of their challenges, whether they relate to the boards' leadership, financial positions or governance. There has been some consistency—if I can put it that way—in terms of which boards have been in that bracket and which have not.

One of the key planks of the report is that, rather than looking to recover to what we think was an already unsustainable position—both for some local health boards and nationally—there is an opportunity for the Government to grasp reform. In the report, we highlight some examples that we have seen over the course of the pandemic; the Government needs to galvanise those reforms on a consistent basis and to spread learning and innovation across all areas and all services. We point in particular to the ambitions relating to the care and wellbeing portfolio, which would give the Government some of the strategic capacity that it needs to generate consistent experience.

I will bring in Leigh Johnston to talk about the lessons that have been learned, and about how good practice and forward thinking are being developed.

Leigh Johnston (Audit Scotland): Good morning. The convener mentioned boards that we have identified as being those that are struggling and are getting additional support from the Scottish Government. It is fair to say that a number of boards are struggling in relation to their financial position and the efficiency savings that they have been making. There has not been focus on that throughout the pandemic. The Scottish Government has funded the unachieved savings and has fully funded all NHS boards throughout the pandemic. As we move forward, we need medium-term and longer-term financial planning to come back into play so that we can fully understand the future financial position of the boards.

As the convener said, there are opportunities across the board relating to the innovations that we have seen throughout the pandemic, such as the NHS Near Me service and the opportunities that it offers, especially for our more rural NHS boards. Such innovations will enable boards to provide services that are more accessible for people in their areas, and to deliver more affordable services.

The Convener: You mentioned Near Me—Stephen Boyle might want to come in on this—and we have been hearing quite a lot about patient expectations through our work on other inquiries. Did that come out through the scope of your work and when you spoke to people? Historically, we have had issues with waiting lists, particularly for elective surgery. We are still on an emergency footing, and we had some backlogs even before the pandemic. Did patient expectations come up a lot when you spoke to people during the course of your inquiry?

Leigh Johnston: As we set out clearly in our report, it is very important that the patient is at the centre of changes to how services are delivered. Patients should have a say and be able to set out their priorities. As services and their delivery change, that, too, should be clearly communicated to the public.

The Near Me service has, of course, been evaluated. One of the clear findings was that that type of service delivery does not suit everyone, so choice must be available. Such services suit some people; that takes us into questions about digital inclusion and, obviously, about some of the more vulnerable members of our population who still want face-to-face contact with their healthcare providers.

However, among our report's key messages are that patients and the public need to be at the centre of service changes and that, once any such change is implemented, it is clearly communicated in order to ensure that people are clear about how to access services.

The Convener: Do you want to add anything, Stephen?

Stephen Boyle: I will make just a brief comment, convener. I should, for absolute clarity, point out that we did not interview members of the public in compiling our report. Instead, it has drawn from a range of sources including interviews with health board and Government officials, a review of evidence and so forth.

That said, Leigh Johnston has highlighted one of the main points. The fact is that, in relation to all the innovations—which are touched on in exhibit 7 of the report, and of which the Near Me service is a very clear example—we are unlikely to step back from the digital technologies. Indeed, we have noted the Government's plans for bringing in a digital health strategy later this year to cover some of the data gaps and to ensure that things are regularly evaluated. At the heart of that will be patients' experience and expectations of the service, and ensuring that their voices are heard and that they shape future reform of the NHS and social care.

The Convener: That was very helpful. I will now bring in my colleagues, who have questions on this matter. I call Sue Webber.

Sue Webber (Lothian) (Con): Welcome to the meeting, Mr Boyle. It is nice to see you face to face.

It has been eight months since the Scottish Government published its NHS recovery plan. What is your assessment of the progress, if any, that has been made since then? As you have rightly stated and as we all understand, there is no quick fix, but we now have an opportunity to reform the system instead of recovering to pre-pandemic levels. However, given that the statistics that are coming out of the NHS with regard to accident and emergency, cancer, delayed discharges and diagnostics are all bleak, do you think that the Government's plan is working?

Stephen Boyle: We made it very clear in the report that, at the time of its publication, the NHS remained on an emergency footing and that, while we were compiling our audit work, the challenge of tackling the Covid pandemic was writ large. We also noted that the Government had begun to turn its attention to the future and to recovery and reform, and that it had received submissions from health boards in that respect.

I will ask Leigh Johnston to say a bit more about the assessment of what individual health boards have stated, but our overall assessment is that the plan is ambitious and is centred not just on recovery of the backlog. That said, I draw the committee's attention to one of the exhibits in the report—I am looking for the correct one; I think that it is exhibit 4—in which we set out some of the pandemic's impact on a number of specialties in which there has been an increase in demand, a reduction in activity and, consequently, an increase in waits for patients. On top of that, the committee will be familiar with the fact that many patients who would have been expected to present for services did not do so. As a result, the scale of the backlog remains uncertain.

As I have said, our assessment is that it is an ambitious plan that is centred and predicated on recruiting, training and retaining enough medical and nursing professionals to deal with the scale of the backlog that is to be tackled. As a result, it is probably not possible for us to say definitively, at this stage, whether or not things are on track.

Before I hand over to Leigh Johnston, I should say that we welcome the Government's commitment to publishing an annual update on progress against the recovery plan. That feels to us as though it is in the right place in terms of supporting transparency, managing patients' expectations and public scrutiny.

We also set out in the report our very clear plan to undertake more work in that area. We will track and monitor progress to support the committee and parliamentary scrutiny; that is likely to be part of our report on the NHS for 2022. I ask Leigh Johnston to say a bit more about the recovery plans for boards.

09:45

Leigh Johnston: As we outline in our report, the boards had several concerns about their ability to recover and remobilise services. We have seen some of those concerns play out. One of the major things that they were worried about was the uncertainty about how the pandemic would continue. In late summer and early autumn last year, the boards were starting to turn their attention to recovery, but then, of course, the new variant appeared and that took their attention

away. We saw the pressures that the hospitals came under, in addition to all the winter pressures. Those pressures continue as we speak; that takes boards' focus away from remobilising.

The boards were also very concerned about workforce issues. There are several aspects to that, including their ability to recruit staff in sufficient numbers and the fact that the on-going pandemic has affected staff capacity. There have been high levels of sickness, which reduces capacity in hospitals, and the on-going infection prevention and control measures that are in place further reduce the capacity of staff in healthcare settings to deal with the number of patients that they would like to deal with.

Another key finding that we outline in our report relates to the Scottish Government's introduction of the clinical prioritisation framework, for people whose cases are more urgent being seen more quickly. We have yet to see publication of the data from that measure. We made the recommendation for that data to be published in our 2020 report and in our 2021 report. It would provide transparency to the public and give assurance on how NHS boards are dealing with the backlog of patients, if we could see the data related to that clinical prioritisation framework.

Sue Webber: Thank you for those responses.

Mr Boyle, you mentioned earlier that the NHS has consistently failed to deliver on all of its historic staffing ambitions, and you stated that the new recovery plan is predicated on recruitment and retention of staff, so staffing is obviously key. I might not have got the wording exactly right, but I hope that that gives the gist of it. Do you get the sense that what the recovery plan sets out is the reform that is required and is not just tackling the long-standing staff issues that we have? Bringing about the reform that is needed is different to tackling our recruitment challenges.

Stephen Boyle: That is an important distinction: it is not about recovery to where we were before the pandemic. My predecessor and I both noted before the pandemic that the NHS was operating in an unsustainable financial position, that there were service challenges, that there were changing demographics in the country and the unsustainable nature of the delivery of services.

I will address your very direct question. The report touches on the challenges in recruiting staff, retaining them and—to use the Government's own word—nurturing staff and their experience, while understanding that the pandemic has been an incredibly demanding period, without precedent, for NHS workers over the past two years. In the report, we note that historically the NHS has struggled to deliver on its staffing commitments. Exhibit 6 sets out some of the challenges and aspirations for the workforce before the pandemic and, in addition to that, some of the staffing aspirations to deliver the recovery plan. We do not yet know how successful those will be.

As I mentioned earlier, we welcome the commitment to publish annual progress updates. Transparency is really important for parliamentary scrutiny and for enabling the public to understand how progress is being made.

The distinction between recovery and reform is a vital one, as we emphasise in the report. If we can, we should use the opportunity—I hesitate to use the word "opportunity"—to reform as we look to rebuild services. The detail of the Government's plans for a national care service will be important with regard to what reform looks like in respect of health and social care services.

We note the need for caution in relation to the capacity of the NHS to deliver on all its ambitions for reform while rebuilding and recovering services. That is part of our on-going work, but it is probably a bit early for us to be definitive about whether the Government is yet in a position to enable that to happen.

The aspirations and the intention of the Scottish Government's new care and wellbeing portfolio will be key, as it has been identified as the driver of the capacity to deliver the reforms. We will continue to work on that.

Paul O'Kane (West Scotland) (Lab): Good morning. I am interested in how social care and the national care service sit alongside each other. In January, you produced a report in which you highlighted the scale of the challenge in social care, which sits alongside the pressures that exist in the NHS. We know that delayed discharge and blockages further up, at the other end of the scale, are often caused by a lack of availability of care packages.

In your January report on social care, you said that the Government needed to move faster to take action to alleviate some of the issues than the five-year timescale that is envisaged for a national care service to be set up. Are there things that can be done now to alleviate the issues that are being experienced in the NHS and to provide social care more quickly? Do those include improving pay and conditions of staff, further recruitment of new care staff and looking at care packages across the country?

Stephen Boyle: You are correct in your analysis of the joint paper on the challenges that social care faces that the Accounts Commission and I published earlier this year.

As we mentioned in that paper and have said again this morning, it will be a number of years before the ambitions for a national care service—

whatever shape that takes and however those ambitions are delivered—are met. We also highlight that Scotland's social care sector already faces severe pressures, the addressing of which cannot wait for the structural change that will be brought about by a national care service.

You mentioned some of the things that might help to alleviate that situation, such as fair work practices that build on the recommendations from the Feeley review of adult social care. We acknowledge that it will be difficult to bring about structural change and the integration of health and social care services, which will be a number of years down the line, while tackling the significant challenges that exist in that sector at the moment.

As you suggested, the social care system does not operate in isolation. The NHS relies on social care to deliver for all of Scotland's patients. As we have sought to capture in the report, data shows that, during the pandemic, there was a clear reduction in delayed discharges. I am not drawing any conclusion about the appropriateness or value of that. Delayed discharges dropped significantly in the early part of the pandemic, but the level is now back up, largely, to what it was before the pandemic.

I do not wish to underestimate the scale of the challenge in bringing about recovery, reform and transformation, and I have been careful not to do so, but I want to make a final comment. I am sure that the committee will be familiar with the fact that last year was the 10th anniversary of the Christie commission report and the aspiration of the Christie group for a more preventative-based public service delivery model for care. There is a sense that there has been a missed opportunity, in that that has not come to fruition. We looked to set that out in January's paper, but we really want to highlight the interconnectedness and urgency of some of the challenges that Scotland's social care faces.

The Convener: Sandesh Gulhane is next. He also has some questions on workforce planning, so he will carry on after he has asked the question on this theme.

Sandesh Gulhane (Glasgow) (Con): I want to turn our attention to long Covid and the work that is being done within NHS Scotland on that. We have seen that there are more than 90 clinics in England, but there is none in Scotland, as far as I am aware. What have you seen of the work that is being done on how to address long Covid? What plans are you hearing about for long Covid clinics or treatment for patients through reform of the NHS? This is obviously a huge area, with more than 100,000 Scots suffering.

Stephen Boyle: In the report, we note the impact of long Covid and recognise that the term refers to a range of factors and symptoms. I will bring Derek Hoy in to say a bit more about the Government's longer-term plans.

We also note the difference in scale between the investment in plans elsewhere in the UK relative to those in Scotland. It is fair to say that work is being done on long Covid, but it is at an early stage and our ability to be clearer than we are in the report about the Government's plans is limited, as is our ability to evaluate them and investigate further. The committee might wish to pursue such a line of inquiry with the NHS and the Government more directly.

I will pause there and invite Derek Hoy to say a bit more about our work in this area.

Derek Hoy (Audit Scotland): As the Auditor General has said, we do not go into a tremendous amount of detail about long Covid in this report. However, we know that the Scottish Government is taking two branches of action. It is funding a range of research projects into long Covid, and it will take a bit of time to get the results of those. As Dr Gulhane rightly pointed out, there are no specific clinics in Scotland. The Scottish Government has decided that a one-stop shop, or a single approach, is not the right way forward. It will take a different approach that will be more centred on the patient, and it expects services to wrap around the patient; that is the terminology that is being used. That is a different approach from what is being done in England.

It is also a policy issue, so we do not want to comment on it too much. The Scottish Government's long-term approach seems to be to deal with long Covid within the scope of existing services rather than putting something specific in place. Obviously, we are still in the early stages of that and we will have to wait to see how it develops. I hope that we will be able to do some more work on that in the future.

The Convener: Sandesh, would you like to continue with your questions on workforce planning?

Sandesh Gulhane: Yes, thank you.

All that is very interesting, but it is not quite what I understood to be happening. I am also interested to hear that work on long Covid is still in its early stages.

In 2019, Auditor General, your predecessor pointed out that the Scottish Government's commitment to recruit 800 GPs would be all but undone by people leaving the profession. Is there enough focus on retention? Do we need to see more ambition if we are going to get a grip on workforce planning?

10:00

Stephen Boyle: Audit Scotland has produced a number of reports on the NHS workforce—GPs, nursing and other services—over the years. That led us to the overall judgment that we make in the report about the historical struggles that the NHS has had to recruit and retain enough workforce to deliver its commitments.

Clearly, those have been compounded by the pandemic. We touch on the fatigue and burnout that have been experienced by NHS and social care workers over the past two years. We then connect that to the extent of the forward plans to recruit many more additional staff to deliver on the plans to tackle the backlog of patients.

The workforce strategy to deliver those plans is ambitious. As I mentioned, we welcome the plans to have transparency around that in order that the public, the committee and the Parliament can track progress in a transparent way. We will continue to be involved in the audit work. It is my clear expectation that, through our report on the NHS in 2022, we will comment on, audit and track progress against the delivery of the workforce plan.

It is difficult to say terribly much more at this stage; we note that the strategy will need to be accompanied by more detail and more evidence of progress in relation to the workforce and other significant components, such as the national treatment centres and other factors. I am sure that the committee will want to explore that.

It is also worth pointing out that another key plank is that all that needs to be accompanied by high-quality and complete data in order for us to be able to track progress, both in a workforce context and in relation to the delivery of services. That remains part of our forward work.

Sandesh Gulhane: I wanted to come on to that. It is very difficult, if not impossible, to know what you need and what you have to do if there is a lack of data. Are we seeing progress, or a lack of progress, in relation to data collection and analysis? What gaps are there, and how do we fill them?

Stephen Boyle: I will bring in Leigh Johnston to say more about the gaps in a moment.

It is difficult to give you assurance on whether we are seeing sufficient progress on high-quality data. In the report, we note gaps in relation to workforce, primary care, and community and social care settings, as well as health inequalities. All those need to be tackled so that there is a complete and transparent picture across all areas of public services and we can be clear on what impact and outcomes are being achieved from public spending. At the moment, the data gaps are a real barrier to that.

Regrettably, Audit Scotland produces many reports that comment on data gaps as being one of the barriers to our ability to track outcomes and know how well public spending is delivering and what it is achieving. To give appropriate balance, we recognise the data strategy that is pending and the Government's understanding of the issues in its response to the report. We look forward to seeing progress so that those data gaps can be filled and there is transparency in relation to delivery in the health and social care services context.

The Convener: Gillian Mackay has questions on data that go wider than workforce planning.

Gillian Mackay (Central Scotland) (Green): Good morning and welcome. I am sorry that I cannot be with you in person today.

Audit Scotland previously recommended that data on waiting times based on the categories in the clinical prioritisation framework should be published. However, that has not yet happened. To what extent is there transparency regarding how long patients will be expected to wait and how they are prioritised?

We sometimes hear from constituents that they are placed on a list but then hear nothing more about when they will be seen or how they will be prioritised, which obviously impacts on a patient's experience of the system as a whole.

Stephen Boyle: Good morning, Ms Mackay. I will certainly remember to bring in my colleague Leigh Johnston this time to support my response.

The clinical prioritisation framework is itself an important statement of transparency. However, we have not yet seen accompanying that the managing of patients' expectations about how long they will be required to wait for receipt of the services and treatment that they are waiting for. We made that point in our overview report in 2020, and we repeated this year that it is a key component of public involvement and understanding, and of managing patients' expectations of what they can receive from the NHS.

I will turn to Leigh to say a bit more about what we understand of the Government's plans in that area.

Leigh Johnston: We made that recommendation last year. As I said, until we see the data attached to the clinical prioritisation framework, it will be difficult for us to make any analysis of the progress that is being made towards dealing with the backlog. In our conversations, Public Health Scotland has assured us that the data will be available later this

year. There are issues, which Public Health Scotland is trying to work through, with the reliability and robustness of any data at that level. Once it has sorted those issues out, the agency will make the data publicly available.

The clinical prioritisation framework is clear about how patients will be dealt with and how they will be followed up to check that they are still at the right level of prioritisation. However, we have not examined in detail whether that is happening in practice. Once we have the data around the framework, it will enable us to do a bit more analysis of what progress is being made.

Gillian Mackay: The report notes that data on primary care needs to be improved. For example, it says:

"Data on the number of GP appointments carried out is not available".

How important is it that that data is collected and what impact would that have on how services are planned?

Stephen Boyle: You are right in what you say. It feels like a surprising omission. We recognise that many patients' journeys start at the general practitioner and go elsewhere as required. Therefore, part of our findings and recommendations in the report is that there needs to be a complete suite of data, including data on GP appointments, to support planning, especially as part of the wider thinking on the care and wellbeing portfolio—the reform of the NHS.

If we are moving to a more preventative model and shifting the balance of care as we have talked about for many years, having a complete suite of data, including the number of GP appointments and appointments elsewhere, will be central to supporting that reform thinking. We look to the data strategy as part of that thinking and will see what comes of that. We will look to review it. If the committee wishes to pursue it in the meantime, it might wish to do that with Public Health Scotland or the Government.

The Convener: We have some more questions on data.

Sue Webber: It might be best if Leigh Johnston answers this question, because it is about the clinical prioritisation framework.

Leigh, you mentioned that you were not getting a clear sense of whether patients were correctly prioritised. Indeed, while patients wait—sometimes for up to two years—their symptoms can get significantly worse, so the question is whether they are progressing to the higher priority level. Do you get a sense that, when people lose hope that they might ever get seen, they take themselves off the NHS list? Are we measuring the people who go off to private providers to have their treatments?

Leigh Johnston: We do not have that data either. We did not examine it in much detail. We presented the findings of our report to the Public Audit Committee. It has recently written to the Scottish Government and that is one of the questions that it posed in the letter, in which it asked for further data and evidence. It will be interesting to keep an eye on the Government's response on how many people have gone to the independent sector to meet their health needs.

Emma Harper (South Scotland) (SNP): I have a quick question about data. We need data to show transparency of information and to make sure that we are following the care pathways and so on. Is that data part of the data supply chain that comes from health boards, integration joint boards and our local authorities? Who procures that data? Does the Government provide it for you?

I get feedback that everybody is so busy churning out data that they cannae get on with their job. The same clinicians and care co-ordinators are being asked to provide data rather than doing what they want to do, which is to get people on to waiting lists, into appointments and moving forward so that they are not just waiting to be told when their hip operation will be. The other part of the data process is about people engaging in a care pathway.

Stephen Boyle: You are right that a balance needs to be struck between collecting data and delivering patient care. We do not want to create more bureaucracy than is necessary. However, the report sets out that the gaps that exist are barriers to understanding how well health and social care services are being delivered; looking to the future, those gaps are also barriers to delivering some of the necessary reforms to the delivery of health and social care services.

There is a transparency point and there is a planning point. There is also a requirement for leadership that probably only the Scottish Government can provide, given its reach into different parts of public service delivery—I am thinking not only about primary care settings, health boards and IJBs but about starting off on the right footing with some of the reforms to the national care service in relation to high-quality data involving the Government and its local authority partners. I agree that there is a need for balance and that data collection should not be seen as interrupting patient care in the here and now, but as giving the right platform on which some of those reforms and future aspirations can be built.

Emma Harper: What Audit Scotland needs from the Scottish Government is different types of data. Can you say what data is missing, so that the

Government can provide you with data that you can analyse.

Stephen Boyle: Our needs, in terms of our assessment, are pretty small. We point out in the report that the Government does not have the complete suite of data that we think that it should have to make decisions about the delivery of health and social care services and do the thinking about reform.

As far as what we require is concerned, we use data to report publicly, through our audit work, on how well public money is being used and what outcomes are being delivered by public services. However, it is not just us who need that data; the Government and patients need it, too. We have touched on transparency and reform already. A complete data set is also needed to address the gaps that we currently have.

The Convener: Emma, would you like to continue on to the theme of prevention and early intervention?

Emma Harper: Yes. I am interested in prevention and early intervention. Public Health Scotland became fully functional in April 2020. What up-front preventative actions need to be taken to support better public health across Scotland?

Stephen Boyle: I will bring Leigh Johnston in again to say a bit more about the plans. It is reasonable to recognise that the aspirations of Public Health Scotland, as originally conceived, have not been delivered, given its role during the pandemic, which it continues to play. I am sure that the committee is aware that Public Health Scotland was established as a joint programme between the Scottish Government and the Convention of Scottish Local Authorities as a way of focusing on prevention and health inequalities, but by virtue of the pandemic, much of the progress made by the programme has been interrupted while Public Health Scotland supported the delivery of Covid-related services.

As we emerge from the pandemic, that thinking is really vital in a public health context, as we look to address some of the inequalities in health outcomes that were very clear in Scotland and which remain. Some of the statistics that we touch on in the report around the challenges related to both life expectancy and healthy life expectancy show that progress has stalled over the past decade. There is a clear role for Public Health Scotland, through its work in partnership with local authorities and the third sector, to make progress in that space.

I will bring in Leigh Johnston to say a bit more about what we know about Public Health Scotland's plans.

10:15

Leigh Johnston: As the Auditor General has said, Public Health Scotland has been very focused on the response to the pandemic; that has been its main focus for the past couple of years. It is starting to look at its future plans, and early intervention and prevention and a whole-system approach will be very much at the centre of those.

For a number of years we have commented on the importance of early intervention and prevention for the sustainability of not only the health service but social care. In our report "Health and social care integration", we say very clearly there that there is a real challenge in moving investment from service delivery to early intervention and prevention. That is a struggle that we always see in services.

In "NHS in Scotland 2021", we talk about the care and wellbeing portfolio that the Scottish Government is developing, which is intended to provide the vision and strategy for the NHS. One of that portfolio's key components is preventative and proactive care that will proactively keep people well, independent and in the care setting that is most appropriate to their needs. The development of the portfolio is at an early stage, but we will keep a close eye on it. The intentions are good, but we need to see how it progresses and is implemented in order to see whether more progress can be made in that area.

Emma Harper: I have a brief supplementary. Public Health Scotland's website has loads of virtual learning opportunities for clinicians and for anybody in healthcare and social care. It has modules on health inequalities and human rights, health and wellbeing, tackling poverty, mental health, health at work and the public health workforce. There are loads of learning opportunities that people can log into and look at—they are out there and available now.

Will Audit Scotland look at the uptake of those virtual learning experiences, who is involved in taking them up and whether the Government should be doing more to support Public Health Scotland's work to ensure that the opportunities in that learning environment are taken up by health boards, local authorities and IJBs?

Stephen Boyle: We have not set out any plans to analyse the success and the outcomes that are achieved from the learning environment that Public Health Scotland offers health professionals. We can take that away and have a think about it.

However, I would expect Public Health Scotland to have a clear idea of the outcomes that are being delivered from the offer that it is making to health professionals through its learning channels. We can see whether we have any information on that and share it with the committee. If we do not

have any information, the committee might wish to pursue that line of inquiry directly with Public Health Scotland.

Emma Harper: Okay.

Sue Webber: We have spoken about how the shift to the preventative agenda can be made. How can we monitor progress in putting the preventative agenda for healthcare into place, rolling it out and delivering it? Is there data to support the monitoring of progress when it comes down to the outcomes? It is a challenge that we hear a lot about, but how do we actually monitor progress?

Stephen Boyle: Tracking and monitoring what outcomes are changing for the people of Scotland and what is being achieved from public spending is the key challenge. Over the past few years, that challenge has not been successfully met. A considerable amount of public investment will be required and the backlog will need to be tackled if we are to see the envisaged reform of health and social care services.

The public and parliamentarians will want to be satisfied about what outcomes are being achieved, whether the patient experience is improving and whether taxpayers are getting good value for that investment. Audit Scotland has a clear role in some of that, but, more directly, the Government and health boards will want to set that out clearly—this has been mentioned once or twice—in the annual report on tackling the backlog. Together with work through the care and wellbeing portfolio, that will be at the strategic centre of the shift in the balance of care in Scotland. That is what matters; there has to be transparency about what comes next.

Sue Webber: My second question goes back to drawing parallels with the clinical prioritisation framework, which I am certainly aware of. The Scottish Government is piloting prehabilitation for cancer patients, but what value do you attach to rolling out the scheme more broadly across the NHS, particularly for those who are in the various categories in the prioritisation framework, to make sure that people are in good shape, rather than in worse shape, when they eventually reach the point at which they will have treatment?

Stephen Boyle: I will perhaps turn to colleagues to see whether they are more familiar with some of the detail around that than I am. First, I reiterate a point that has been made a couple of times. Everybody who is waiting for services needs to have a clear expectation about when they will receive those services, whether they are waiting for cancer treatment or for one of the other treatments that are in the clinical prioritisation framework. We are clear in our recommendation that if that does not happen, a key part of transparency is missing. We welcome the fact that, as Leigh Johnston has mentioned, Public Health Scotland is committed to making that happen later this year, and we look forward to seeing that come to fruition.

I turn to Leigh Johnston or Derek Hoy to say a bit more about that.

The Convener: I will bring in Leigh.

Leigh Johnston: I am aware that the committee has mentioned the pressure on A and E, and where diagnosis or treatment has been delayed, we now find that people are presenting at A and E more unwell than they previously were. If we can roll out and implement initiatives and ways of delivering services that are shown to be good practice, that have been evaluated and that work well, there must be benefits from that.

The Convener: Emma Harper has a question before we move on.

Emma Harper: We have talked about prevention. The Government has provided financial support for deep-end practices—for example, in Govan in Glasgow—to monitor engagement. Part of that financial support was for link workers, anti-poverty work and giving people welfare advice. We have that data now to show engagement work and support by deep-end practices. We can look at that data and see the value of investing in that project. Is that something that we can audit right now?

Stephen Boyle: I am not familiar with that example, but I recognise from many practices that exist that shifting the balance of care and preventative healthcare will not just be delivered through NHS spending. Social care, which is closely connected, and some of the spending on education, such as through pupil equity funding, will all have a contribution to make in shifting the balance of care and reducing health inequalities.

One of the features of our reporting over many years, particularly with regard to the integration of health and social care, has been what has felt at times like anecdotal examples of progress rather than system-wide changes that will deliver some of the dramatic improvements that we would hope to see. We need to harness those examples of good practice—from Glasgow and elsewhere—and share them more widely so that we can apply them in the right setting and build on them to benefit all of Scotland. Again, Public Health Scotland, the Government and the national care service, whatever form it takes, will have a clear role to play in making that happen.

The Convener: We will move on to talk about health inequalities. We are about to conduct an inquiry into health inequalities, and your report suggests that there is an overarching strategy to

tackle health inequalities that goes across all the Government portfolios, not just the health and public health portfolios. Most people we speak to in the committee agree that that approach, which involves looking at what happens in society more generally, is the right way to address health inequalities, rather than simply considering what happens in our hospitals and GP surgeries. What kind of data is Audit Scotland looking to have in order to audit that overarching strategy?

Stephen Boyle: There is no straightforward answer to that, unfortunately. This morning, we have spoken about addressing some of the data gaps. We understand that the Government intends to tackle that problem through the data strategy.

I will restrict myself to speaking in overarching terms about the need for system-wide data to analyse what outcomes are being achieved from public spending. Too often in our reporting we talk about not only data gaps but gaps in data-sharing arrangements between public bodies. The committee might take an interest in that, given the focus on the system-wide approach to tackling health inequalities. The issue exists not just in the NHS, and there is clearly a role for local government, third sector organisations, integration authorities and education authorities. Data is not being shared across partners as it should be.

We are looking for a leadership strategy that sets out clearly the impact that public spending should have on tackling health inequalities. I do not wish to be blasé about that by suggesting that that is a straightforward thing to do, but it really ought not to be an insurmountable problem for us. We ought to be able to have a clear vision and strategy that is reviewed, commented on and reported on annually so that we can track progress in a transparent way.

There are many other planks to the issue. In the next month or so, we will publish a report on the progress on the roll-out of social security, which is something that will have a longer-term impact on tackling health inequalities.

The Convener: If you were to do some work around, for example, the housing strategy or tackling fuel poverty, would you factor in the potential health benefits of any spend in those areas?

Stephen Boyle: Yes. When we look at spending, one of our key priorities, which is shared by our colleagues in the Accounts Commission who oversee local government spending, is the issue of its wider impact on inequalities. That cannot be done on a single-system basis, so, across our audit work, we attempt to weave multiple strands of public spending into our reporting so that we can see the impact that they have on tackling inequalities, and we will perhaps broaden that out into other themes, such as climate change. That approach is very much part of our work.

The Convener: Susan Webber has some questions on health inequalities.

Sue Webber: I have only one question. In your report, you note that there is no overarching strategy for tackling health inequalities in Scotland, despite the endemic nature of the persistent and acute inequalities that exist. We have just heard about some of the activity that you are undertaking in that regard, such as on weaving the strands of spending across different portfolios. What conversations have you had with the Scottish Government on the need to establish urgently an overarching strategy on health inequalities that would act almost as a linchpin as we recover from the pandemic?

10:30

Stephen Boyle: I will probably bring in Leigh Johnston again here, but with regard to looking to the future, we have had regular engagement with the Scottish Government and NHS officials. We note the anticipated work of Public Health Scotland and the Government’s creation of a health inequalities unit within its health and social care directorate and will be tracking any progress made as a result of those changes. Therefore, it is probably too early for us to pass any judgment in that respect, but we note and share the ambition to have a clear strategy for tackling health inequalities. As we said in the report, some of the outcomes for the people of Scotland will have been very clearly impacted by the pandemic, and we have noted the other challenges that are affecting healthy lives. We are continuing to review the area; it remains one of our priorities.

The Convener: Did you have any questions on this theme, Carol?

Carol Mochan (South Scotland) (Lab): As quite a new committee member, I am finding that it is taking a while to process all the information. I am quite interested in issues around health inequalities and life expectancy, but I would say that we have known about all these things for some time now. How often have we tried to pull together this kind of data, and, if we have tried to do that in the past, what barriers have we come up against?

Stephen Boyle: I will do my best to respond to that, but I would say that the issue of data gaps that we discussed earlier is a clear barrier, as are some of the data-sharing arrangements between public bodies and the way in which we set budgets for delivering public services. As we have commented in some of our recent reports on the pandemic—this point applies to the situation

before the pandemic—we generally set such budgets on a silo basis; in other words, there is a local government budget, an NHS budget and, in more recent years, a budget for integration. However, as the convener has suggested, health inequalities touch on many different aspects of public spending, and it is not that straightforward to be clear which part of such spending is having the biggest impact on reducing health inequalities. A number of steps need to be taken with regard to having high-quality data and evaluating what aspect of public spending is having the intended outcome before we can have a complete sweep of the necessary information and make those kinds of assessments.

Carol Mochan: With regard to making this particular transition, we have talked about who is responsible in health and social care services, but do we need leadership at Government level to really push for this to happen?

Stephen Boyle: We know that there are plans for a data strategy that will set out how the Government will tackle data gaps and measure the impact in that respect, and we will look to track that in our work. I am sure that that will be of interest to the committee.

The Convener: I call Evelyn Tweed to ask about NHS finance.

Evelyn Tweed (Stirling) (SNP): Good morning, Mr Boyle. In your opening statement, you made some very positive comments about how change can happen quickly and effectively, as the pandemic showed. You also noted that the NHS was not financially viable pre-pandemic and that Covid exacerbated that situation.

You have referred to the Scottish Government's ambitious plans, but do you feel positive about them? Is the Government moving towards achieving real sustainability for the NHS?

Stephen Boyle: It is too early to tell whether the ambitious plans for recovery will be achieved. In the report, and in the discussion this morning, we have touched on the fact that any success in delivering recovery and tackling the backlog will be reliant on recruiting, retaining and nurturing NHS staff.

Although the past is not a predictor for the future, we point out that there have been challenges. We welcome the Government's commitment to being clear and transparent and to publishing an annual report on its progress. We will factor that into our future work.

You are right that we have previously said—and we repeat in the report—that the model for health and social care in Scotland was not sustainable for a variety of reasons. There is an opportunity for reform. That will be built into plans for the national care service and for the delivery of NHS services. There will be a shift in the balance of care and more focus on prevention and on tackling health inequalities. That will require multiple strands of work, which must be woven into a clear and measurable strategy.

Evelyn Tweed: The Scottish Government put a lot of money into the NHS during the pandemic. Do you feel able to comment on how effectively those resources have been spent?

Stephen Boyle: We have done some work on that already. We have produced briefings on the vaccination programme and on use of personal protective equipment.

The report sets out the scale of change in NHS spending. There was an additional £2.9 billion of funding for the delivery of NHS services. It cannot be said often enough that we recognise that that was during a pandemic, when the NHS remained on an emergency footing. That is all clearly accounted for. We have audited the finances by auditing Scottish Government consolidated accounts. That is set out in the report.

What happens in the future will depend on which outcomes are achieved in the long term. That will be part of our future programme.

Sandesh Gulhane: I will pick up on Evelyn Tweed's question about how the NHS in Scotland was not financially sustainable before the pandemic. I have two questions.

First, what steps could we take to make the health service more efficient?

Secondly, what work have you done, or seen, on silos and pots of money? I can give an example. A department might have one pot of money to employ locums and another pot of money for its current staff. Money cannot cross from one pot to the other, so current staff are not paid what locums are paid and therefore do not do internal locum work.

Stephen Boyle: I will take those questions in reverse order.

Scotland has 14 territorial health boards and a range of national health boards, all providing services to deliver and support patient care. Some strands of that are provided nationally; some are for individual health boards.

The use of locums is an interesting example. Two years ago, we reported on the challenges that NHS Highland had in recruiting for some GP services in a remote and rural setting. It was having to pay very significant additional costs to deliver those services. The board has reflected and has worked on that and we know that some of those costs have been reduced.

That ties in with some of our earlier conversation about opportunities to share learning across Scotland, so that all health boards can benefit from some of the thinking about how to deliver efficiencies. It is really important that that work continues. We know that it happens in some places. We can broaden that out to look at how we set and use budgets for services. Accountability follows budgets. The accountability for delivering services typically rests with individual boards, but the delivery of longer-term outcomes requires multiple bits of accountability.

When we thought about Christie, one of our conclusions was that individual accountable officers across Scotland would be measured on the delivery of performance for their own organisation, as opposed to the delivery of wider outcomes. Thinking about the opportunity for reform of accountabilities might be part of one of the ways to unlock the more joined-up, collaborative working that will be required to deliver changes in services and shift that balance of care, which we consider as one of the current barriers. There is opportunity and a route through that, but it will require some significant thinking and changes to the current arrangements.

The Convener: We will now ask you about some of your future plans.

Paul O'Kane: Key to many of our questions this morning is the issue of scrutiny and the on-going assessment of the work that has been done in order to deliver change. What future work on health and social care is Audit Scotland currently planning to undertake?

Stephen Boyle: Our forward work programme mirrors some of the key challenges that public services in Scotland face. We will continue to produce an annual overview of the NHS in Scotland. We will think carefully about the themes for that this year. The current report is, of course, Covid dominated, but previous iterations of the report have been more focused on finance, which is always of particular relevance to the work of Audit Scotland. We expect that theme to increase in future years. As I have already mentioned, I anticipate that the recovery of the NHS will be a clear part of next year's report and the reports beyond that.

We will also be auditing and reporting on progress of the reform of the NHS through the work of the care and wellbeing portfolio. I will bring in my colleagues to say more on this in a moment, but we plan to undertake further work on mental health services in Scotland. As Scotland progresses towards a national care service, together with our colleagues in the Accounts Commission, we will prepare a programme of work on that work and how the service will look. There is probably an appropriate analogy to be made with some of the work that we did on health and social care integration and continuing that theme.

As the convener mentioned, we will weave in equalities across all our work and build them into those themes.

The final point that I will mention is climate change. In the report we briefly consider the commitment to the 2040 target and the 2030 interim targets, and, looking at the scale of the NHS Scotland estate, what changes will be made that will require some long-term thinking. That is all part of our forward work programme.

Leigh Johnston and Derek Hoy might want to add anything that I have missed.

Leigh Johnston: That has covered everything. For our NHS in Scotland report this year, we have plans to focus on the recovery plan and its progress, taking a closer look at workforce planning and the new strategy that came out following the publication of our recent report. We will take a closer look at that and make some assessment of it.

We are in the middle of scoping our mental health audit. We produced a report on children and young people's mental health services back in 2018. The plan is to look at adult mental health services this year. As the Auditor General said, we also made a commitment to do a third performance audit on health and social care integration. That will be a joint report between the Auditor General and the Accounts Commission. We will have to consider the scope of that in the context of the national care service and what we might want to look at in that respect.

The Convener: Emma Harper has a question.

Paul O'Kane: Convener, I have not quite finished.

The Convener: I am sorry. We will come to Emma Harper after Paul O'Kane.

Paul O'Kane: I am tempted to go into a shopping list of things that I would like Audit Scotland to look at, but I will resist.

10:45

Given the pressures that exist in emergency medicine, which this committee hears quite a lot about, and, more broadly, in respect of A and E attendance and the Scottish Ambulance Service, will a particular focus be placed on emergency medicine?

The committee is holding an inquiry on pathways into care, and we are looking at GP and pharmacy services and the different levels of service that can be offered. Is there any work

forthcoming from Audit Scotland that might help to supplement and support our work?

Stephen Boyle: We do not have any definitive plans around emergency medicine, but we acknowledge the challenges that A and E departments are facing, some of which have been exacerbated by the pandemic.

We referred to the plans for and innovations in pathways in our overview report. I suspect that that will be the best place for us to comment in the short term. As ever, none of our plans is fixed in the medium or longer term.

Perhaps the committee is aware that we changed how we plan our audit work in the light of the pandemic. Before, we would typically set our plans a year in advance, with fairly indicative programmes for years 2, 3 and 4. However, we need to be more flexible than that to enable us to report more regularly and provide different styles of outputs—you mentioned some of the briefing papers that we have done. We will continue with that, which gives us the flexibility to respond to the live challenges that public services face.

We will keep those two areas under review if they are not included in the overview report.

Emma Harper: I am sorry for jumping in earlier.

I will not give you a shopping list of things to look at either. However, when we had NHS Highland before the committee, I asked it about the reduction emissions that are due to mileage not being travelled because folk are now holding Teams meetings or using Near Me. Are you planning for remote and rural working? How does that support net zero ambitions?

Stephen Boyle: A bit like health and social care integration and similar to the national care service, we are planning a programme of work on climate change for how Scotland's public services intend to move towards net zero. Many public bodies have made a commitment, but what matters now is that they have a clear plan for how they will deliver on their net zero interim and long-term targets.

You are right that a reduction in mileage is one factor. As has been touched on already, in the operation of public bodies' estates, making their buildings more efficient to support net zero ambitions is another factor.

If we do not undertake a stand-alone piece of work—I suspect that we will not; we will probably comment on climate change across all our activity—public bodies should set out in their own reporting how they plan to move towards net zero. We will audit that through our annual audit processes.

Emma Harper: People are now keener to live in remote or rural areas because they can work from home two or three days a week and travel only one or two days, rather than having to drive every day to the central belt or, in Dumfries and Galloway, from Stranraer to Dumfries. That is what I was thinking about with emissions reductions linked to mileage or unnecessary travel, whether by clinicians or staff who support the work of clinicians.

Stephen Boyle: I understand. You mentioned NHS Highland and, if there is no dominance of attending work or living in the central belt, a positive knock-on effect might be that Scotland's remote and rural communities are made more accessible and more attractive places for people to live and work. We will think carefully about how we factor that into our work on not just climate change but the sustainability of services. That is one for us to take away.

The Convener: I will bring in Gillian Mackay on that specific point.

Gillian Mackay: I will follow up on what my colleagues have been asking about and on what was said earlier about data. I have spoken to a couple of stakeholders about the climate impact of medicines. In your opinion, do we have sufficient data to be able to assess any climate impacts of changes in medication and how we prescribe medication? I am thinking about asthma inhalers in particular. The powder ones are infinitely better for the planet than the more traditional ones are. Do we have the data that we would need to assess the impacts of moving away from, for example, the more harmful types of asthma inhalers?

Stephen Boyle: I am not sure that we have that data. We have not looked at that through our work.

Before I turn to colleagues to see whether they can add anything, I note that, again, we would expect the NHS to track and monitor the totality of its carbon emissions—not just emissions from how it delivers services but those that are brought in from elsewhere.

Emma Harper: I am interested in the issues relating to inhalers. It is not just about one measurement of hydrofluorocarbons as the delivery mechanism for salbutamol, for example; it is about the whole measurement of the bunch of plastic in a dry-powder inhaler that cannae be recycled as easily as some of the components can be. We need to be careful about saying that we will not give people certain inhalers and will give them only dry-powder inhalers, because the issue is much wider than just looking at propellants for those inhalers.

The Convener: As you can see, we are really interested in your future work on climate change.

As a former convener of the Environment, Climate Change and Land Reform Committee, I note that we asked the NHS about the issue when we considered the Climate Change (Emissions Reduction Targets) (Scotland) Bill.

Before we let the witnesses go, I will bring in Sandesh Gulhane to ask a final question.

Sandesh Gulhane: I am not as disciplined as Paul O'Kane and Emma Harper. [*Laughter.*] I am keen for long Covid to form a cornerstone of future work because of how little we know about it, although we are definitely gaining understanding. Given the number of people who are affected and the devastating impact that long Covid is having, I am keen for work to be done on it. Would Audit Scotland be able to look at what is going on, how it is going on, what planning there is, how money is being spent and whether patients are getting what they should be getting?

Stephen Boyle: I am very happy to take those comments away and factor them into our thinking. As you have seen, we make reference to the issue in our report. Leigh Johnston rightly said that the Government's plans to support patients with long Covid are generally at health board level. We expect there to be clear reporting on progress and on the impact of the funding that has been allocated.

As well as the need for clear data and definitions, we will think carefully about how we can contribute to public scrutiny and understanding of the issue. We will factor that into our thinking and plans.

The Convener: I thank Mr Boyle for his time this morning and Derek Hoy and Leigh Johnston for their support.

We will take a break before we move to the next item on our agenda.

10:53

Meeting suspended.

11:15

On resuming—

Health and Care Bill

The Convener: Item 3 is an evidence session on a further supplementary legislative consent memorandum relating to the United Kingdom Health and Care Bill—LCM S6-5c, which was lodged on 12 April 2022. I welcome Humza Yousaf, the Cabinet Secretary for Health and Social Care, who is accompanied by Scottish Government officials Sam Baker, who is acting head of unit in infected blood and abortion services; Robert Henderson, who is team leader in the intergovernmental and international relations unit; and Lucy Orren, who is a solicitor for the food, health and social care division. I thank you all for joining us.

I believe that the cabinet secretary has an opening statement to make.

The Cabinet Secretary for Health and Social Care (Humza Yousaf): Good morning. I hope that you are all keeping well and keeping safe.

I thank the committee for inviting me to discuss the amendment to the Health and Care Bill regarding the extension of the offences in the Human Tissue Act 2004 and the Human Tissue (Scotland) Act 2006 to cover the supply of human organs outside the UK.

The LCM before the committee is the third supplementary LCM for the Health and Care Bill that I have placed before the Scottish Parliament. I have written to the UK minister, Mr Argar, to express my concern about having to make several requests for valuable parliamentary time to be spent on considering the legislation as a result of the piecemeal way in which the bill and the UK Government's engagement with the Scottish Government have been handled.

The amendment includes provisions for additional criminal offences when a person who is habitually resident in Scotland, or who is a UK national, travels outside the UK to buy, or to in any way arrange a form of reward for, an organ. In my LCM, I have recommended that the Parliament grant legislative consent to the UK Government's amendment. Although we do not have any evidence to suggest that the small number of people who live in Scotland who have organ transplants abroad pay for their organs, the Scottish Government is committed to tackling unethical organ donation practices. The amendment would deter anyone who might want to consider travelling abroad and paying for an organ, and it would allow progress to be made towards implementation of the Council of Europe Convention against Trafficking in Human Organs.

I am happy to take any questions that the committee might have.

The Convener: Thank you. I note that you agree with the substance of the amendment. However, you mentioned the UK Government's piecemeal approach. We always keep an eye on the consultation processes for LCMs or statutory instruments that come our way as a result of changes that the UK Government makes to legislation. Has there been enough consultation between the two Governments as part of the process?

Humza Yousaf: You make an important point. Because of the way in which the UK Government's amendment has been brought forward and the requirement for an LCM, there has been a very limited amount of consultation. That is the source of our frustration, which, in turn, limits our ability to consult.

As you would imagine, we have consulted our clinical advisers on organ donation. The national group on organ donation has managed to take a view, and no concerns have emerged. In principle, we are in agreement with what the amendment seeks to do. However, if we had had more time—if the process had been gone through in a more structured and less ad hoc way—we would have been able to have more meaningful and deeper consultation with a variety of stakeholders.

Emma Harper: Good morning, cabinet secretary. Does this legislative consent memorandum on illegal organ donation, procurement and so on mean that our own Scottish legislation—the Human Tissue (Scotland) Act 2006—will need to be amended?

Humza Yousaf: No, it should not require any further amendment. My understanding is that this UK-wide legislation—which, as I should have said in my opening remarks, does not include Northern Ireland; because of elections, its Parliament is not sitting—does not require anything further from us. I am happy for officials to elaborate on that, but if the Parliament agrees to the LCM, we will not be required to make any further legislative amendments.

The Convener: Sam Baker wants to respond.

Sam Baker (Scottish Government): I confirm that that is correct. There would be no need for us to make any further amendments. The UK bill will amend the 2006 act, so no further changes will be required.

The Convener: Thank you for that.

Emma Harper: I have another quick question. If someone whom we thought was on a transplant list for a kidney, for example, showed up looking for anti-rejection medication and seemed to be doing well, we might assume that they had received an organ somewhere else. Does the legislation support better traceability of organ surgery, procurement and so on? Given that anti-rejection medication is part of the treatment following transplant, would that be a trigger for pursuing what might be criminality if someone had received an organ outside Scotland?

Humza Yousaf: We need to be careful here. We know of a small number of instances of individuals going abroad for organ transplants—mainly kidney transplants. Indeed, a constituent of mine went abroad for such a reason, and, as far as we know, there was nothing to suggest that anything unethical happened in that respect. There are protocols and processes in place to ensure that we in Scotland are informed if anyone goes abroad for an organ transplant.

You are right to say that, once an individual has had an organ transplant, things might come out in the conversation about the aftercare that they receive in Scotland, and a clinician would then have to judge whether anything would need to be reported, because there had been a breach of the law or because an offence had been committed.

The legislation does not put an onus on clinicians to do that. Indeed, I suspect that they have to make these really difficult judgments all the time. Of course, I do not need to tell Emma Harper that. Given her background, I am sure that she well understands the situation. In some respects, the change in the law might be an additional bit of information for those working on organ donations and transplants and aftercare, and they should be made aware of it.

Sue Webber: In Scotland, we now have, for want of a better phrase, an opt-out approach to organ donation, but what else is the Scottish Government doing to increase the number of organ donors in Scotland? Would that not help to limit the risk of commercial dealings around organ transplants?

Humza Yousaf: That is an excellent question. Ultimately, we do not want anyone to have any reason to go abroad for a transplant, and a lot of work is being done in that area. I am happy to give more detail about that, but I would just note that a core theme of our "Donation and Transplantation Plan for Scotland: 2021-2026" is to increase the availability of transplants. I suppose that, in this respect, an important aspect of the plan is its focus on increasing the number of living kidney donors. As I said earlier, the majority of transplants that have been undertaken abroad have been kidney transplants.

We are also working to encourage people from as many diverse backgrounds as possible to come forward for to donate organs, which is key. In many instances, people of similar ethnic

backgrounds will be a better match for organ donation. I hope that if more people from more diverse backgrounds come forward, that will militate against the need—or perception that there is a need—for someone to have to go to another country where there are donors with their ethnic background to get a possible match. A lot of good work is being done, and I commend the "Donation and Transplantation Plan for Scotland: 2021 to 2026" to the member if she has not had the chance to see it yet.

The Convener: I thank the cabinet secretary and his officials for answering our questions.

Subordinate Legislation

Sports Grounds and Sporting Events (Designation) (Scotland) Amendment Order 2022 (SSI 2022/86)

National Health Service Pension Schemes (Scotland) Amendment Regulations 2022 (SSI 2022/100)

National Health Service (Charges to Overseas Visitors) (Scotland) Amendment Regulations 2022 (2022/114)

The Convener: Item 4 is consideration of three negative instruments. The first instrument is the Sports Grounds and Sporting Events (Designation) (Scotland) Amendment Order 2022, which updates the Sports Grounds and Sporting Events (Designation) (Scotland) Amendment Order 2014, which is also known as the 2014 order, so that it properly reflects the current lists of grounds and events to which the act should apply. The 2014 order also needs to be updated to include football matches in the competition in the Union of European Football Associations Europa Conference League. The 2022 order will achieve that.

The Delegated Powers and Law Reform Committee considered the order and made no recommendations, and no motions to annul the order have been lodged. As members have no comments, I propose that the committee makes no recommendations on the order.

Members *indicated agreement.*

The Convener: The second negative instrument is the National Health Service Pension Schemes (Scotland) Amendment Regulations 2022, which implement reforms to the national health service pension schemes for NHS workers in Scotland. The purpose of the regulations is to close the legacy scheme on 31 March 2022, and move all active members to the 2015 scheme on 1 April 2022 to ensure that rules around additional pension elections and transfers into the existing scheme for transitional members are applied consistently to those who were previously classed as full protection members.

The Delegated Powers and Law Reform Committee considered the regulations and made no recommendations, and no motions to annul the regulations have been lodged. Do any members have any comments?

Sandesh Gulhane: I note the work that we are doing and the reasons that we are doing it, but we are not doing enough on pensions. The current NHS pension scheme is hindering NHS

consultants from doing extra work, because essentially, they are having to pay to go to work. We also need—and I would love it if we could do that in the committee—to have an employers' contribution recycling scheme, as we have in Wales, to enable consultants to do more work. I would like to see more work being done on that and for the committee to write to the cabinet secretary about that.

The Convener: Occupational pensions are reserved to the UK Government, although that does not refer to the regulations that we are considering. However, your comments are on the record.

I propose that the committee does not make any recommendations on the regulations. Do members agree?

Members *indicated agreement.*

The Convener: The third and final negative instrument for consideration is the National Health Service (Charges to Overseas Visitors) (Scotland) Amendment Regulations 2022, which will ensure that overseas visitors from Ukraine who have been displaced as a result of the on-going conflict can receive relevant healthcare services provided by NHS Scotland at no charge.

The Delegated Powers and Law Reform Committee considered the regulations and made no recommendations, and no motion to annul the regulations has been lodged. Do members wish to make any comments?

Sandesh Gulhane: I note that councils will be granted about £10,000 to look after the health needs of each person who comes from Ukraine. Is that money being used in the regulations and is it ring fenced to help people from Ukraine to address their healthcare needs?

The Convener: We will have to write to the Government about that so that we can take the matter forward.

I welcome the measure in the regulations. It is the right thing to do for people who are probably suffering a great degree of trauma as a result of their experiences in their home country.

Does the committee agree to make no recommendation on the regulations?

Members *indicated agreement.*

The Convener: At its next meeting, on 26 April, the committee will consider its approach to an inquiry into health inequalities and a draft report on its inquiry into the health and wellbeing of children and young people.

That concludes the public part of our meeting.

11:31

Meeting continued in private until 11:49.

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

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

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