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Health, Social Care and Sport Committee

Tuesday 27 June 2023

Session 6

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
23rd Meeting 2023, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

John Burns (NHS Scotland)
Stephen Lea-Ross (Scottish Government)
Michael Matheson (Cabinet Secretary for NHS Recovery, Health and Social Care)
Richard McCallum (Scottish Government)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 27 June 2023

[The Convener opened the meeting at 09:00]

NHS Scotland (Performance and Recovery)

The Convener (Clare Haughey): Good morning, and welcome to the 23rd meeting in 2023 of the Health, Social Care and Sport Committee. I have received no apologies.

Today, we have a session with the Cabinet Secretary for NHS Recovery, Health and Social Care, Michael Matheson, further to our recent scrutiny of front-line national health service boards. I welcome the cabinet secretary. With him are John Burns, who is the chief operating officer of NHS Scotland; Stephen Lea-Ross, who is deputy director health workforce in the Scottish Government; and Richard McCallum, who is director of health finance and governance at the Scottish Government.

I invite the cabinet secretary to make a brief opening statement.

The Cabinet Secretary for NHS Recovery, Health and Social Care (Michael Matheson): Good morning, convener, and thank you for inviting me to meet the committee this morning. This is my first appearance at the committee since I was appointed as Cabinet Secretary for NHS Recovery, Health and Social Care. I welcome the opportunity to engage with the committee, and I look forward to discussing a range of vital issues in the weeks and months ahead, as recovery and renewal of the NHS and social care services continue.

I also thank the NHS boards for continuing to provide information to the committee, which has been taking evidence about their performance in recent weeks.

Ministers and Scottish Government officials regularly meet representatives of all health boards to discuss matters of importance to local people. It is my strong belief that the Scottish Government should not only fund, but should empower and enable boards to make the decisions that they feel are most appropriate to their localities and areas.

We acknowledge the pressures that are felt by boards across the country as we all continue to deal with the aftermath of the biggest shock that the NHS system has felt since its establishment some 75 years ago. We continue to prioritise investment in front-line services. We have provided an increase of some £730 million for NHS boards through the 2023-24 budget and an additional £200 million in-year support above initial plans to support the financial sustainability of NHS boards. That means that no board is more than 0.6 per cent from NHS Scotland resource allocation committee parity.

In addition, we continue to provide constant support and guidance to NHS boards to ensure that they are doing everything that they can do to provide the best possible care for people in their localities. Our new prospectus for the year ahead demonstrates our collaboration, with a key part of our plan to deliver year-on-year reductions in waiting lists being to deliver additional capacity through our national treatment centres in NHS Highland, NHS Fife, NHS Forth Valley and NHS Golden Jubilee National Hospital.

Another good example is the work that is being done to increase the workforce through hiring an additional 800 staff from overseas. That was helped by £8 million of funding in October last year. We set an ambitious target of recruiting some 750 additional nurses, midwives and allied health professionals from overseas; I am pleased that, due to the hard work of health boards, we have exceeded that target. That is the kind of joint working between central Government and local boards that I will hope will go from strength to strength, as we go forward.

I am happy to respond to questions.

The Convener: Thank you very much, cabinet secretary. We will move straight to questions.

Evelyn Tweed (Stirling) (SNP): We know that older people now generally enjoy better health than their predecessors of equivalent age did, but we also know that they still have significant and multiple health needs. What is the Scottish Government doing to examine that demand and those health needs?

Michael Matheson: The burden of disease will continue to increase during the next 20 years by something in the region of 21 per cent, largely because of the demographic shift that we are experiencing as the population gets older. We need to do a number of things to tackle that burden of disease, one of which is to make sure that we are implementing all the right preventative measures to reduce the impact that lifestyle options can have on health. All the public health measures that we take to improve people's health will be important.

Secondly, we need do all that we can to tackle the social inequalities that drive health inequality, including by tackling poverty and reducing child poverty. Those are key factors in helping to ensure

that we focus on preventing ill-health because of social inequality.

Thirdly, we need to continue to develop and adapt our services to meet the increasing demand from older people and people who have multiple conditions so that we can manage their long-term conditions effectively in a way that improves their health and allows the health services to be sustainable.

Prevention is critical, but we also need to adapt our services to meet the increasing demand that we will face as our population gets older. We will also need effective integration between our health and social care services, given that they are critical to one another, particularly in helping older people to manage at home by giving them the support and assistance that they require.

Evelyn Tweed: We know that rural and island health boards are experiencing significant challenges because of demographic shifts. They are also having particular difficulties in filling vacancies. How will the Government ensure that those health boards are supported so that the urban-rural divide does not become a thing and those inequalities do not come to pass?

Michael Matheson: I will probably bring in John Burns to say a bit more about some of the work that we do. The particular challenges that the rural boards face are that they can experience difficulty in recruiting specialist staff because the number of patients that they deal with in some departments means that positions are not so attractive to the staff who need to be recruited to them.

There are a number of reasons for that. For some time now, clinical care has been undergoing ever-increasing specialisation and has moved away from being provided on a more general basis. The general physicians whom we had many more of in the past are becoming fewer and more specialised. That has driven behaviour that results in clinicians wanting to work in specialist centres where there is much more throughput so that they can see the range of patients that they are looking for and build up experience and so on. That is much more challenging in our rural boards, especially given that the population levels are much lower and the boards are not able to sustain the same services.

For a number of years now, we have been putting in place arrangements for managed clinical networks in which we can use clinicians in some of our bigger centres to provide clinical support to boards in our rural and remote areas. Sometimes that involves their going out and holding clinics in those areas, and sometimes it is about supporting clinicians in those areas in their decision making and reviewing of patients. That is one of the ways in which we support our rural and island boards so that they can sustain services. Of course, that sometimes means that patients have to come into the larger clinician centres for specialist care and interventions.

John Burns can maybe say a bit more about some of that work, which has been on-going for some time now.

John Burns (NHS Scotland): I will add a couple of points to the cabinet secretary's comments. First, when I visit the boards of our island and rural communities, I am struck by the fact that they are at the forefront of attempts to innovate, to work differently and to bring new ways of delivering services to their communities. It is important to have collaboration, regional working, networking and building of a critical mass of services, but it is also about using technology in new ways to deliver services. Again, I have seen very good examples of island boards collaborating not just in their natural region of the north-east but across Scotland, which shows the strength of technology and the ability that it brings to deliver services in new ways.

Secondly, rural and island boards are also at the forefront of considering new roles and upskilling staff to take on enhanced or advanced roles, which is helping to deliver services in their communities and across their populations.

Sandesh Gulhane (Glasgow) (Con): Good morning, cabinet secretary. The Scottish Government's report, "A Scotland for the future: The opportunities and challenges of Scotland's changing population" highlights that

"An ageing population, with an increasing number of our 'oldest old' citizens, has the potential to transform our population's health and care needs."

That situation is particularly prevalent for islands. What is the Scottish Government doing to address the issue of population decline in parts of rural Scotland and the islands? How does that work feed into, in particular, recruitment issues there?

Michael Matheson: Do you mean in terms of trying to reverse depopulation in rural and remote areas?

Sandesh Gulhane: Yes.

Michael Matheson: You will be aware that we are taking forward a range of work to try to make our rural and island areas attractive locations, whether through addressing connectivity and economic activity issues to make rural and island areas viable places for communities to grow and thrive, or through measures that support people to live in those areas. For example, the islands growth deal and the Argyll and Bute growth deal are about helping to reverse depopulation by putting in infrastructure to make communities attractive and to encourage people to live in them.

When I was the minister who was responsible for taking forward growth deals, a key part of what we were trying to do, working in partnership with local government, was to put in place measures that we knew would help to support the people who were already there, but would also help to make those communities attractive for people to move to and live in.

One of the big issues that was often flagged up to me was digital connectivity. The digital superfast broadband programme was all about having the infrastructure in place to support rural and island communities in order to make them attractive locations, by giving people the ability to live, to work from home or to base a business there. Although they go well beyond my portfolio, those are the sorts of measures that the Government takes, on a broad economic basis, to make our rural and island communities attractive locations for people to stay and to go to live in.

Emma Harper (South Scotland) (SNP): Good morning, cabinet secretary and everybody.

I want to pick up on health not being the only portfolio that needs to address the issues that we face in relation to population and so on. How is the Government working with other portfolios, including housing? I know that the Cabinet Secretary for Rural Affairs, Land Reform and Islands is working with Paul McLennan, who is the Minister for Housing. Is the Scottish Government taking forward the necessary cross-portfolio engagement?

09:15

Michael Matheson: No single action alone would help to address issues around population shift and make our rural and island communities attractive for people to live and work; rather, a range of actions will have to be taken. You will be aware, for instance, of actions that have been taken in some rural areas on housing, as well of measures that we are planning to take to free up housing capacity in our rural and island areas. There is a combination of factors to consider, including transport infrastructure, housing, digital infrastructure, good-quality and sustainable health services, access to education and so on. They all play key roles in helping to make our rural and island communities attractive places for people to live and stay in. They cut across all Government portfolios, and some of the work that we are taking forward in Government is on trying to ensure that we take a consistent approach to delivering them and that we are prioritising them.

Emma Harper: Thank you.

The Convener: Our next theme's questions are from Tess White.

Tess White (North East Scotland) (Con): Good morning, cabinet secretary and officials.

The chief executive of NHS Grampian told the committee that her health board will still be in deficit by 2028, which means that, like many health boards, it will have to make very difficult decisions in order to plug the hole. What action is the Scottish Government taking to support health boards' financial sustainability in the short-to-medium term?

Michael Matheson: As you will be aware through the inquiry, funding is allocated to health boards through the NHS Scotland resource allocation committee formula, and is distributed on the basis of population share, geography, deprivation factors and so on. That approach has been taken for some time now and continues to be taken. As has been the case historically, we also provide tailored support to individual health boards if they face financial issues in-year and require financial support as a result. In the short term, therefore, if NHS Grampian requires additional financial support, we will try to provide it, if the funding is available.

Equally, we will continue to make progress with our use of the NRAC formula. I know that NHS Grampian has raised the issue of parity. As I have mentioned, we have already provided another £200 million in this financial year to try to close that gap further, and we will continue to try to do that in the medium term, too. We will, through the combination of short-term tailored support and the move towards NRAC parity, try to manage the issues for boards including NHS Grampian.

Tess White: Thank you.

The Convener: An issue that was raised by just about every health board that the committee met was the cost and use of locum staff. Some of the fees that our island boards, in particular, were looking at to engage locum consultants were quite eye-watering—indeed, the figure of up to £3 million a year was quoted in one case. What action is the Scottish Government taking to reduce reliance on locum and agency staff and to shift things more in the direction of making the NHS a more attractive place in which to be a permanent member of staff?

Michael Matheson: There are a couple of points to make in that respect. First, NHS Scotland has, like the rest of the NHS across the United Kingdom, used agency staff at various points. If you look at the figures, you will see that over the past 12 months there has been a bit of a spike in the number of agency staff being used. Greater use of such staff largely reflects the significant recruitment challenges that the NHS faced over the course of the pandemic. In the past month, we have applied additional restrictions on boards in

order to reduce our agency spend. To put that in context, though, I point out that our agency spend is a relatively small proportion of our overall budget: I think that it is less than 2 per cent.

If there is a need for flexibility in relation to staff, we would much prefer to work with NHS bank staff who are on NHS contracts and NHS terms and conditions. We have applied some restrictions on boards to make sure that they are focusing much more on using bank staff where necessary.

We must also make sure that the NHS is an attractive place for staff to work. That is why the agenda for change settlement was critical, through taking forward measures to address issues related to pay and conditions in order to ensure that NHS Scotland is seen as an attractive place to work and to take one's career forward.

Work was also done through, for example, the nursing and midwifery task force to improve recruitment to and retention within NHS Scotland.

Those are all areas of work that are about retaining staff within the NHS and making it an attractive place to come and work. It is also about looking at new routes into the regulated professions.

Reform around workforce, training and planning, alongside work on pay and conditions and much greater focus on use of NHS bank, rather than agency, staff are all part of the combination or package of measures that we are taking forward to reduce our dependency on locum and agency work.

The Convener: Inflation—in particular, private finance initiative costs—was also raised by several health boards. What impact is the current rate of inflation having on public-private partnerships and PFI payments, and what impact that is having on NHS budgets?

Michael Matheson: Obviously, inflation is having an impact on the NHS across a range of areas. From procurement of food through to drugs, equipment and maintenance costs, all areas of the NHS are, by and large, impacted by inflation costs, alongside energy costs. That is placing a very significant strain on NHS budgets.

I will get Richard McCallum to say a wee bit more about PFI and the inflationary impact. Inflation is having an impact across a range of areas within health and social care, outwith PFI.

Richard McCallum (Scottish Government): I will make two points on PFI. The situation is impacting on boards: the inflationary impacts of how the PFI deals were structured when they were initially set up mean that there is a cost associated with rising inflation. It is particularly impacting boards that have a large PFI within a fairly small health board setting. NHS Forth Valley or NHS Fife might be such examples.

We are doing two particular things, on which we are working closely with the boards. The reality is that contracts are in place that need to be honoured. However, contract management of PFI arrangements is really important. Through NHS Scotland assure, we—with NHS National Services Scotland—are working closely, especially with boards that have PFI arrangements, to ensure that we maximise value from the contracts.

The second point is that we recognise that some of the early PFIs will, in the not-too-distant future, be coming to an end. Some of the work that we are now doing with boards is about planning beyond the life of those PFI arrangements. We can give updates on that as it plays out over the next few years.

The Convener: That would be helpful for the committee.

I believe that Carol Mochan has a supplementary question.

Carol Mochan (South Scotland) (Lab): Good morning.

My question relates to all those points. The following quote from Claire Burden, who is from my area, is important. She said that she

"inherited a deficit of £26 million"

when she entered her post, and that

"Going into 2023-24, our underlying position is deteriorating"—[*Official Report*, *Health, Social Care and Sport Committee*, 21 March 2023; c 13.]

I wonder whether the cabinet secretary feels that decisions, or lack of decisions, by his predecessor are causing on-going problems for the boards. Can you demonstrate to us how you might treat some of the decisions that need to be made with some urgency? The feeling from the boards was that, although the situation was acknowledged, there was no urgency around decision making that might help in the long term.

Michael Matheson: I am surprised by that, because I do not get such feedback when I talk to boards about the financial challenges. They readily acknowledge that we are aware of the significant pressures that they are under, so I am surprised if some have given you the impression that you described.

Carol Mochan: Boards recognise that you see the difficulties, but they say that there does not always appear to be urgency about decision making on how to resolve difficulties.

Michael Matheson: I think that I understand what you mean. Are you talking about providing more money?

Carol Mochan: I think—

Michael Matheson: Let us take an example. Are you talking about Fife?

Carol Mochan: It is Ayrshire.

Michael Matheson: We have provided NHS Ayrshire and Arran with tailored financial support because of the pressures that it is facing. If you asked whether issues arise because my predecessor did not make decisions about X, Y or Z, I would say that my predecessor gave a commitment to increase health spending in this parliamentary session by 20 per cent, and we are well ahead of the trajectory for where we should be on that.

The decisions that my predecessor made have increased the investment that is put into health services ahead of what was planned—we are ahead of where we should be. That demonstrates the determination to provide as much financial support as possible and the urgency with which action is being taken to provide additional finance to our boards. In this financial year, there is an additional £730 million and, alongside that, a further £200 million of support.

None of that demonstrates a lack of urgency, understanding or leadership on doing what we can. However, our health service is experiencing the same challenges as other parts of the public sector are because we are going through a period of austerity, which is having a direct impact on the Scottish Government's budget, and because inflation means that we are experiencing a significant increase in the costs that are associated with running public services, which is having an impact on those services. All of that is having an impact on our budget.

Another point that is worth not losing sight of is that we are still dealing with the pandemic's consequences. Costs are still associated with Covid-19, but Barnett consequentials for dealing with Covid-19 have stopped, so we now have to meet those costs from core budgets.

Extra money is being provided where it is available, and that is being done earlier and more quickly, which shows urgency. However, alongside that is the fact that we must deal with a range of additional cost pressures, which are having a significant impact not just on health services but across the public sector and in society as a whole—households are also experiencing that in their budgets.

Carol Mochan: Are you confident that you have a plan, with urgency, that will help boards even further than the provision of funding does?

Michael Matheson: I am absolutely confident that we will do everything that we can, but I will not sit here and say that all the financial challenges in NHS Scotland or the public sector will be magicked away—that will not happen. Across the UK, we are going through a period of austerity in the public finances, which is having an impact on our budget and means that we must try to manage the finances as efficiently and effectively as possible. You can be assured that we will do everything that we can to provide financial support where possible, but that will be within the limits of what is available to us to invest in the health service and other public services.

Emma Harper: I have a quick supplementary question about terms and conditions and about staffing. Nurses at bands 5 and 6 in Scotland are paid 6 per cent more than their counterparts in England, so we have seen nurses fae Carlisle relocate to Dumfries and Galloway. However, we have seen the opposite with the social care workforce—people who have trained in Dumfries and Galloway have then moved to England.

I am interested to know whether improving terms and conditions for social care staff is an aim in the development of the national care service, so that we can have equivalence in terms and conditions and retain our social care staff in Scotland. Right now it seems that staff are leaving Scotland to go to England because they can get improved salaries and terms and conditions.

09:30

Michael Matheson: Some of that is geographically specific to your part of the world. For example, one challenge that we have around social care in my area is staff from social care going into areas such as healthcare, because they are more highly paid.

Historically, our social care workforce has been less valued than our healthcare workforce, which is reflected in the rate of pay. That has been the case for some time, and we have to try and address that. We provided additional funding to local authorities to support increases in social care staff pay partly to try to stem the loss of staff from social care into healthcare and other areas of employment where they can get higher rates of pay. We have a commitment to aim for £12 an hour over a period of time, and we are doing some work around what that timeframe will look like.

The other part is that we need to provide good career pathways for those who work in the social care setting, and provide them with opportunities to progress their career and move into other parts of the care setting. For example, someone with considerable social care experience might be interested in doing nursing, but might not necessarily have the academic qualifications that get them into a university place to do a nursing degree.

We are looking at aspects such as the nursing apprenticeship, and we are taking forward that work through the nursing and midwifery task force to look at how we can create pathways into areas such as nursing for people from social care. We want them to see that there is a very clear pathway for them to follow, but we also want to make the social care setting appear as a much more attractive professional setting for staff.

My view is that pay is a big part of that, and we will do what we can to try to help to address the issue, because, historically, social care work has been paid less and had a lower relative value than healthcare work, which has resulted in challenges around the social care workforce.

Emma Harper: I should probably remind everybody that I am a former NHS Dumfries and Galloway employee and am still a registered nurse. I should have said that at the start.

The Convener: Sandesh Gulhane has some questions on our next theme, which is redesign.

Sandesh Gulhane: Like Emma Harper, I should have said this at the start: I am a practising NHS general practitioner.

Cabinet secretary, we have a worldwide issue when it comes to medicine. We have shortages of all kinds of medicines; at the moment, the biggest shortage that I face in my practice is of dihydrocodeine and paracetamol together. What are we doing to create a smoother path for medicines, especially when it comes to the way that we prescribe and what happens in pharmacies if there is a shortage?

Michael Matheson: You will be more aware than I am whether there are shortages of particular labelled medication or their alternatives. We try to encourage prescribing of alternative medications that might serve the same purpose but might not be the prescribed medication that the person had previously been on.

I do not know whether John Burns can say a bit more about other aspects of prescribing. We try to work very closely with the pharmaceutical industry to smooth out issues around procurement and the availability of medication. Sometimes the challenges that we face are, as you rightly say, not peculiar purely to Scotland or the UK. They can be as a result of a worldwide shortage or other challenges. Some of that will be because of stockpiling of medication.

I cannot remember the exact medications, as it was before I had responsibility for health, but I remember some occasions in recent times when there was concern about access to certain medications—in particular, certain forms of antibiotics. I remember being involved in that and hearing a discussion in which the chief pharmaceutical officer was talking about procuring some medications in advance so that we could hold some of them in reserve, if necessary.

It is a matter of planning around procurement of the medication. Where there are concerns around supply chain issues, it can be a matter of trying to stockpile some medications where that is possible. It is not always possible for all drugs, as some of them may have a short shelf life, but it is about trying to manage those things as best we can within the structures that we have, through procurement and with the help of clinical advisers on procurement and the stockpiling of medication. Those would seem to be most appropriate ways to address the situation.

Sandesh Gulhane: At my practice, one of the biggest issues that I face with redesign involves repeat prescriptions. We do not have electronic prescribing yet. When do you expect that to happen?

Michael Matheson: There is quite a bit of work going on around that at the present time. John Burns could say a bit more about electronic prescribing. Some new information technology infrastructure is being rolled out for general practices, and about 30 or 40 practices have in place some of the new IT system, which will help to facilitate that. The system is due to be rolled out over the next couple of years, which will allow us to move towards electronic prescribing so as to reduce some of the burden. IT infrastructure is key to facilitating that, and the new GP IT system is designed with a view to providing much more around electronic prescribing.

John Burns: I do not have a lot of detail on that, but I would be happy to get more information and provide it to the committee. As the cabinet secretary has said, however, the introduction of the new GP IT system will be an important part of improving the IT infrastructure. I recognise the point that you have made, Dr Gulhane, about the importance of electronic prescribing and the relationship between general practice and community pharmacy. As for the detail, I will ask my colleagues to provide the committee with a briefing on that.

Sandesh Gulhane: Thank you very much.

There is little point doing a redesign when the public do not know what is going on or how to access services. What will the Government do to ensure that the NHS serves the priorities of the people and that people know how to access services?

Michael Matheson: You raise a really important point. A big part of some of the challenges that services have experienced in recent times has involved managing public expectation of services that are available and awareness of the most

appropriate route to access them, whether that is at primary care level or at secondary care level.

We have set out a commitment to taking forward a national conversation, part of which involves the design and provision of healthcare services into the future. That includes how people access healthcare services: when it is appropriate to make a GP appointment and when it might be more appropriate to see a community pharmacist, a musculoskeletal physiotherapist or an advanced nurse practitioner, rather than a GP. It might sometimes be right to attend a minor injuries clinic. Thinking of my experience with constituents, I note that people will consider when they should go to minor injuries and when they should go to accident and emergency, so there is a question around how people understand the best route for them and when they should access emergency departments. There is a need for us to provide on-going dialogue, explanations and information about the best route to accessing the type of support and assistance that people may require at a particular time.

Turning to one of the things that we have introduced more in recent times, we have used NHS 24 to try and manage some of the challenge that we are experiencing in emergency departments in particular. The ability to contact NHS 24 allows people to speak to a clinician or advanced nurse practitioner, who is able to prescribe medication and have a discussion. They can then facilitate the person's prescription, reducing the need to go and see a GP or attend the emergency department. We want people to understand and be aware that those initiatives are available to them, and they might be the best route for them to use.

It is not about doing one thing or the other. There is a need for us to continue a discussion and explore with people the options that are available to them and what might be the best option for them should they require to access healthcare services, whether digital, primary or secondary care.

I do not think that we will ever reach a point at which everyone will know the route that they should take. We will always have to provide an explanation to support people to make the right choices. I do not think that we have cracked it as well as we could. We could probably do more to help people to understand how they access their services.

Part of the future redesign of services is about engaging the public in the process of deciding what health services will look like and how they might want to access them. For example, I expect to be able to do much more digitally in the future, but I know that, for some people, particularly older people, that might not be the right route or tool for them. There will always be a natural transition as some people make more use of digital while others do not, and we need to make sure that we give people the options that best meet their needs as and when necessary.

Emma Harper: Healthcare is so wide ranging that there is loads that we could cover today. I am interested in community pharmacy, which is valuable, and pharmacy first is amazing. The feedback that I have had from community pharmacies is that they sometimes feel undervalued in their work. I am interested to know whether data has been gathered on pathways for referral to pharmacy first and whether pathways are appropriate.

Community pharmacies can be great at things such as checking inhaler technique or checking that people who have chronic obstructive pulmonary disease or asthma have the right inhaler, which helps to keep them out of hospital. That is a matter of people having the right inhaler and the right technique for them.

Community pharmacies should be valued, but do we track whether appropriate referrals are made?

Michael Matheson: I do not know, but I am happy to check whether we have that data. I will come back to the committee on that.

On your wider point, I think that there is a lack of public understanding of the treatments that people can get from a community pharmacy. That is understandable. Let us say that someone has an eye infection and is thinking about making an appointment to see their GP. If they have a mild eye infection they could go and see their pharmacist, who will be able to prescribe a medication that can treat it appropriately. You mentioned inhalers for folk who have asthma or other airways diseases.

There is still a lack of understanding and recognition of what community pharmacies can provide, which is why there is a need for the on-going education of people around what is available through pharmacy services, which are a key part of our primary care services. We need people to use pharmacy services rather than just taking the traditional route of making a GP appointment. By using the community pharmacy, they could be seen more quickly and probably much closer to home.

Emma Harper: Community pharmacists are sometimes challenged in dispensing prescriptions because a pharmacist has to be on site. We now have vending machines, which work because of the way in which the regulations de-list part of the pharmacy to allow vending machines to be used for dispensing medicines. I think that the relevant regulations—those that allow medication to be

dispensed if it is a repeat prescription for medication that has already been assessed for the patient—are reserved to Westminster. Is any work being done on how we can support pharmacists in that way so that community pharmacies can, for example, continue to dispense medications?

Michael Matheson: I am not sure; I would have to check for you. I will be happy to come back to you once we have checked whether we are doing any work on that.

Emma Harper: Thank you.

09:45

Tess White: You have talked about the importance of clinical centres for attracting and developing specialist skills, and you have highlighted that service redesign and enhanced national and regional working are also very important.

There is a concern that "redesign" is a euphemism for a drive to centralisation. Large portions of the population in the north-east, for example, are concerned that they are being disadvantaged as they are having to travel long distances. There are huge issues in the north-east with buses not turning up, which means that many people have to take taxis to travel long distances, such as from Montrose to Perth or to Ninewells hospital. That takes a day and it is very expensive to travel by taxi. How can you make sure that people in rural areas are not disadvantaged by any redesign?

Michael Matheson: I do not think that we have ever been at the point where our NHS has been designed; it is a dynamic process and there has always been an element of redesign in our NHS.

I will give you a practical example that I had to deal with in my constituency. Falkirk and District royal infirmary and Stirling royal infirmary both had orthopaedic units, but it became increasingly apparent that, from a clinical perspective, it was not sustainable to have two separate orthopaedic departments. The clinicians said that they did not have the throughput of patients to achieve the teaching hospital status that was necessary to attract junior doctors, registrars and other staff so that the departments could be viable. We have moved from having two district royal infirmaries in the Forth Valley area to having one—Forth Valley royal hospital—which is a single site that provides that function.

It is sometimes the case that redesigns are not driven by the Government wanting to centralise things for the sake of it but are a result of clinical change and clinical demand. The reality is that we are operating in a global market for clinical skills, which means that some services need to be offered in major centres, because they are not sustainable outwith those settings.

I do not want your constituents in rural areas to experience any reduction in healthcare services but, equally, I need to think about how we achieve a balance in being able to meet patients' clinical needs when it is not possible to get clinicians to work in those areas for the reasons that I illustrated through the practical example from my constituency. In different areas across the country, services have had to be located in a single setting. For example, in the past, we have sought to use managed clinical networks for services such as neurosurgery in Aberdeen. We provided support in Grampian—largely through support from Glasgow and, to some degree, Edinburgh—so that neurosurgical services could continue to be delivered there.

Where clinical expertise and support can be provided by some of our big urban centres to other locations in the country, we have tried to do that and to use that type of design so that we can support rural healthcare. We have used managed clinical networks in some of our Highland areas as well as our island communities for the delivery of certain healthcare services so that we can support clinical services and try to make them sustainable. We will continue to have to be innovative in the approach that we take in an effort to support and retain services in our rural areas as best we can, while acknowledging that there are challenges.

As I mentioned, ever-increasing specialisation is taking place within medicine; it is moving away from the generalist approach that we might have had 30 or 40 years ago. As a result, specialist centres have become more and more important in how clinical services are designed and delivered.

I accept the challenge that exists in your area, and I recognise and acknowledge the concern that you raise. As health secretary, I would not be thinking about redesigning services just for the sake of it and against clinical advice. However, we must recognise that, on occasion, boards have to make decisions on the basis of clinical advice to ensure safe services for patients. We have to take that into account.

We will never get to the point where we have reached a final design—it will always be a dynamic process. We must be innovative because of our large rural areas; we must try to support rural services, where we can, to reduce the need for patients to travel by delivering services as close to people as possible, alongside the increasing specialisation and the need to deliver safe services. We must try to get the balance right, but we might not always succeed and we should not be frightened to admit that—we can revisit such things if necessary. It is a competing balance

and one that we have to try to manage in areas such as Tess White's region.

Tess White: I have a short follow-up question. I understand the need for that delicate balance. However, there are two major issues here. First, with the new redesign and the drive to have centres of excellence, people are having to travel long distances. It is not just a question of time—in many cases, people are very poorly.

Secondly, as our Green colleagues will tell us, there is an additional carbon footprint when people have to travel by car—if they are lucky enough to have one—or take extra bus journeys. It could be a day's travel there and back for treatment. As well as the issue of the pain and upset for patients, there is the additional carbon that is used.

Michael Matheson: It is clear from looking at some of the capital investment that we have made recently in national treatment centres, including in one in the Highlands and the Baird family hospital and ANCHOR centre in Aberdeen, as well as our investment in a new hospital in Orkney, that there is not a preconceived view that more things should be centralised. That is not the approach that we are taking. Where we can make the investment to deliver such services in rural settings and to provide the right infrastructure, we are doing so. I am simply acknowledging that there is a trend towards specialisation in the clinical setting—that is an international trend, not just a Scottish or UK trend.

That is why, as John Burns rightly said in response to an earlier question, our rural health boards are among our most innovative health boards because they have to think about how they can deliver services in different ways. We will continue to do what we can to support them to achieve that. I mentioned the Baird and ANCHOR and the new NTC in Highland, which are examples of our determination to deliver as much as we can in some of our more rural areas in Scotland.

However, we must also acknowledge the need to deliver services that are clinically safe. There might be occasions when it is not possible for us to deliver all the services that we would want to deliver in some of our rural areas, and people will require to travel to urban areas. That is not a new thing—it has always been the case that some people from rural areas have had to travel—but there is an increasing tendency towards that, given the specialisation that has taken place.

We want to see more people being treated at home. We are expanding the hospital at home programme so that more people get clinical care in their own bedroom and their own home, never mind in the local hospital. We have more than doubled the funding for that—we have increased the funding by £400 million to expand the programme further. That has a particular benefit for patients in rural areas.

We need to continue to recognise that it is a dynamic situation, to which we need to continue to adapt. Given the particular challenges that we face around our rural communities, we must be innovative. I will do everything that I can to support our rural health boards to deliver the best service that they can in their local areas.

The Convener: Our next theme is staffing. We have a lot of interest in questions under this theme, so I ask members to keep their questions concise, and I ask the cabinet secretly and his colleagues to do likewise in their answers.

Gillian Mackay (Central Scotland) (Green): Good morning. I will touch on some of the issues that Emma Harper brought up earlier in relation to apprenticeship schemes.

We heard from Professor Grant Archibald of NHS Tayside, who described the challenges that he has faced in the recruitment of healthcare professionals who are not nurses and doctors—people such as estates department staff and allied health professionals—and the effect that that has on NHS Tayside. What more can the Government do to promote those less well-known but still vital roles and the various pathways into them, such as modern apprenticeships?

Michael Matheson: You touched on the sort of thing that we can do to make those areas attractive. Obviously, NHS Scotland has an apprenticeship programme that recruits individuals into a range of non-regulated professions, including estates department staff. That is one thing that we can do.

The second thing that we can do is ensure that staff have good terms and conditions. Thirdly, we can provide alternative pathways into the regulated professions. That could be done through earn-as-you-learn programmes and by providing apprenticeships into programmes that are presently dependent on having a university degree. We could also allow folk the ability to flex into other professional groupings using the skill set that they have—for example, advanced nurse practitioners do some prescribing work.

All those measures play a part in helping to meet some of the challenges. Terms and conditions, training opportunities and routes into training for AHPs and others all play an important part.

Recently, I had a really good discussion with the Royal College of Podiatry, which talked about how important apprenticeship programmes could be for individuals who might already have a career but who want to move into podiatry. They could be allowed to flex into that career through earn-as-

you-learn-style programmes. All of that could have a significant impact.

A pilot project that the Royal College of Podiatry is running with NHS Greater Glasgow and Clyde has been really successful in delivering that, so I agreed to take that information away and consider how we can do more of that kind of work. That is the sort of thing that we need to do much more of in an effort to move folk into the regulated and non-regulated professions.

Gillian Mackay: We have heard from a number of boards about the impact of stress and anxiety on staff wellbeing and, in particular, on sickness absence. Over the past few weeks, we have heard that boards are taking steps to improve wellbeing—for example, by putting in place peer-support networks and "Speak up" ambassadors.

What support can the Government provide to ensure that such schemes are rolled out nationally and that, where there is good practice, it is identified and replicated across the health service so that everyone receives the same support? Is there a minimum standard of wellbeing support that boards are expected to have in place? How is that monitored?

Michael Matheson: I am not sure about a minimum standard, but I am happy to check that for you and come back to the committee on that.

On the staff wellbeing issue, the NHS is nothing without its staff; its staff are absolutely critical, so supporting their wellbeing is of high importance.

If there is one thing that frustrates me—it frustrated me when I was a health minister previously, and it has frustrated me since I have come back into the health portfolio—it is the inability to do things using the once for Scotland approach. If one health board is doing really well in an area, it can be a challenge to get other health boards to adopt that practice. We are doing work on the once for Scotland approach to ensure that, where we see good practice in supporting staff and wellbeing, we can utilise it in other health boards so that that experience and knowledge are shared. We are doing work to support that happening much more effectively.

10:00

It is important to learn from and share boards' experiences. We also provide the national wellbeing hub, which gives staff 24/7 support through a range of different programmes. The key thing is that, where there are good initiatives, other boards should learn from them. Those experiences should be utilised much more effectively.

David Torrance (Kirkcaldy) (SNP): There is a vacancy rate of around 7 per cent for medical and dental consultants in NHS Scotland and I know that it is really difficult to get an NHS dentist in my area. How are we going to recruit to fill shortages in specialised positions within the NHS?

Michael Matheson: There is a combination of factors. To go back to the point that I made earlier, one factor is making it attractive to relocate to the NHS in Scotland. I will bring in Stephen Lea-Ross, who can say more about the workforce, but we undertake considerable work through NHS Education for Scotland to try to ensure that NHS Scotland is an attractive employer and that we provide programmes of on-going training, education and support for our clinical staff.

It is worth bearing in mind that we are fishing for these skill sets in a global pool. We have challenges in getting oncologists, ophthalmologists and endocrinologists because there is a global shortage of people with those skills. We must do everything that we can to support and retain skilled people within NHS Scotland.

In terms of medical recruitment into the NHS, in 2022 we managed to fill 93 or 94 per cent of all junior doctor posts, which is the highest number of junior doctors recruited into NHS Scotland since records began. In the last couple of years, we have increased the number of medical places by more than 50 per cent, or 55 places. Is that right?

Stephen Lea-Ross (Scottish Government): Compared to 2016, intake numbers have gone up by 67 per cent and around 500 places.

Michael Matheson: Increasing training opportunities is one part of managing the challenges. Stephen, do you want to say more about the workforce and what we are doing to recruit people?

Stephen Lea-Ross: We brigade all our work, whether that is for medical or non-medical recruitment, under the auspices of the workforce strategy, which has a theoretical framework approach of plan, attract, train, employ and nurture. We need to look at both ends of the spectrum at the same time.

As the cabinet secretary explained, we have already done quite a lot of work on medical growth and fill rates by expanding undergraduate and foundation places. You will see that continue as we move more of those expanded undergrad places into the pipeline.

The other key aspect is workforce retention. We already have a retire and return approach and the flying finish programme and we have other initiatives that allow people to take a slightly longer and more stratified approach to their careers. Last year, we convened a group to look at consultant retention in areas of shortage and specialist need. The group made three sets of recommendations to

health boards, one of which, pension support, has been dealt with. There were also recommendations about adjusting working and job patterns towards the end of a person's career and about encouraging consultants to make career choices before they get to 60 to allow them to stay in the workplace for longer.

There are things going on on both ends of the spectrum that should, over their career pathway, enable people to stay in post for longer and to adapt to changing needs throughout their careers.

David Torrance: My colleague Emma Harper touched earlier on evidence that the committee has heard that, in rural areas, even if jobs can be filled, housing is a real problem. Have you ever thought about working in partnership with local authorities to build specific affordable housing for NHS staff or thought about giving money to NHS boards to build their own accommodation?

Michael Matheson: I do not think that we have given money to health boards to build their own accommodation. I am sure that some partnership work has been done in the past with health boards and local housing providers around what can be done to support them in making affordable housing available to the boards but, again, that is outwith my portfolio. I would be more than happy to check with my housing colleagues what specific work they are doing with boards to address affordable housing issues. Of course, there was a time in the past when we had accommodation for staff in the NHS, but that obviously changed many years ago.

I will check with our housing colleagues around any specific projects or programmes that they have taken forward. I know that programmes have been developed in some rural settings that are about bringing together public sector investment, which is health, housing and wider community investment, and trying to utilise that money in a way that helps to deliver more infrastructure in an area. However, I am not sure whether there have been specific programmes to provide housing for staff who work in the NHS. I think that it will be a more general programme.

Carol Mochan: Very quickly, following on from Gillian Mackay's questions, would you comment on the safe staffing legislation, the commitment to have that in place by April 2024 and how you think that that is going?

For my particular question, I highlight key points made by board chief executives about staffing. Jeff Ace from NHS Dumfries and Galloway said:

"technically, I cannot afford one in 10 of my workforce, but I clearly need all those people and more to meet the service demands that we are facing."—[*Official Report*, *Health, Social Care and Sport Committee*, 2 May 2023; c 13.]

Ralph Roberts from NHS Borders said:

"There is no doubt that what I hear most from staff is their frustration about not being able to do the job that they came to do".—[*Official Report*, *Health, Social Care and Sport Committee*, 21 March 2023; c 25.]

Claire Burden from NHS Ayrshire and Arran said:

"There is a lot of anxiety: anxiety and stress are key drivers of staff absences, because the current climate is tough."—[*Official Report*, *Health, Social Care and Sport Committee*, 21 March 2023; c 24.]

Is it fair to say that the previous cabinet secretary did not get it right in terms of staffing—staff terms and conditions, recruitment and their place in the workplace? Do you have a plan to take that forward and do you think that you can turn around that staff recruitment and retention issue?

Michael Matheson: You seem to have a particular focus on my predecessor.

Carol Mochan: Not at all. It is just that he was obviously part of the input into the NHS so far.

Michael Matheson: I just noticed that you seem to have a particular focus on him, but let me try to deal with some of the issues.

Carol Mochan: My interest is in knowing whether you are going to change direction in terms of making some of those things actually happen.

Michael Matheson: Okay. Let us try to deal with some of the facts around those issues. In terms of safe staffing limits, work is being taken forward just now through workforce planning, engaging our trade unions, stakeholders and health boards around planning for that. Right now, we are on track to take that forward and deliver it within the next year. It is a complex piece of work, but the working groups around some of that are already progressing.

I wholly and fully recognise the financial pressures and the stress and anxiety that staff are experiencing. A big part of that has been because we have come through a pandemic, which has placed huge pressure on our NHS in a way that it has never experienced in the 75 years of its existence. We all need to recognise and acknowledge that.

If your focus on my predecessor is your intention, and if you want to look for examples of taking very direct and clear action to help to support and reward staff, I cannot think of anything that does that more than the significant improvement that we made in their pay and conditions through the agenda for change. The 14.5 per cent that was provided to staff was the largest uplift for healthcare staff in the UK, and more than was provided by the Secretary of State for Health and Social Care in England. That demonstrates my predecessor's determination to provide financial reward and support to NHS

Scotland staff, recognising the enormous contribution that they made during the pandemic. That is a very practical example of his taking clear action and showing clear leadership in delivering such a significant improvement in pay and conditions.

It does not stop there, because the agenda for change is being reformed as a part of that. Again, that was a direct request from the trade union groups. The working groups that are responsible for taking that forward have already started. For example, the nursing and midwifery task force that I mentioned is already up and running. It is due to have its second meeting, which I will chair. The working groups to look at the reform of different parts of the agenda for change are also being taken forward.

You mentioned terms and conditions as an example of demonstrating our commitment to supporting staff. In what was agreed and provided through the agenda for change, my predecessor demonstrated that commitment in a way that was not done in other parts of the UK, where other health secretaries took a different route and provided less. In my view, that is a clear signal of where our priorities are and how we value staff.

I do not pretend that our NHS does not face significant challenges. We are still recovering from the pandemic and its legacy. We are going through a period of austerity in the whole of the UK, which is having a significant impact on public finances. We have been dealing with record levels of inflation. Households are having to manage a cost of living crisis, which impacts on the health and wellbeing of staff. We are dealing with significant increases in fuel costs, which have an impact on public finances. Construction costs and maintenance costs are all up significantly. All of those have an impact on our NHS.

You can be absolutely assured that I will continue with the approach that was taken by my predecessor in valuing and recognising the staff and the important role that they play in our NHS, and maximising the level of investment that we put into NHS Scotland—as demonstrated by the £730 million that we have put in this year and the further £200 million on top of that, as I mentioned earlier. We are ahead of trajectory on the 20 per cent increase during this parliamentary session. Again, that shows clear leadership in putting finance into the health service where we can.

All those factors will play their part but, equally, we do what we can to support our staff and to recognise the important value—the critical role—that they have within NHS Scotland.

Carol Mochan: Thank you for that. The point—

The Convener: I am sorry, Ms Mochan, we need to move on. Other people have questions. We still have three more themes to get through. I call Emma Harper very briefly, then we need to move on.

Carol Mochan: Of course; I will come back to it. Thank you, cabinet secretary.

Emma Harper: I will be very brief. The Scottish graduate entry medicine programme is unique to Scotland and I am interested in hearing feedback about that. In addition, the Rural GP Association of Scotland has concerns about recruitment, retention and workload. How is the Government working with that association?

Michael Matheson: We have a number of programmes to support rural GP initiatives. Some of that is about financial support—making it an attractive setting for them to work in. Stephen Lea-Ross can say a wee bit more about that and about ScotGEM, which, as you mentioned, is a specific Scotland-based project to support recruitment.

Stephen Lea-Ross: I will be very brief. Broadly, ScotGEM is functioning very well. We look to get a second cohort of graduates. It has expanded from 40 to 55 places. It is all graduate entry and is focused on remote and rural areas, with a particular interest in primary care practice. A lot of the clinical placement activity takes place in Highland. We will consider again, as part of this year's intake in October, whether there is scope for further expanding the number of places, as part of the annual review of the expansion of undergraduate medical places.

10:15

When it comes to specific support for remote and rural GP practice, we continue to fund bursaries for GP specialty training. Last year, we funded 98 of those, and we will fund around 100 for this intake. Again, broadly, there is a very good uptake rate on all of those programmes and we have specific financial incentives for supporting rural practices' recruitment and retention premia as well—looking both at the Scottish index of multiple deprivation and at the remote and rural situation of individual GP practices, including lone GPs.

The Convener: We move to our next theme. Again, can we please have concise questions and concise answers.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): Good morning. Cabinet secretary, you have already touched on how health inequalities flow from socioeconomic inequalities and the added pressure that that puts on NHS services. You are welcome to say a wee bit more if you wish. I am interested in what work can be done to tackle inequality and reduce

poverty, with a clear focus on preventing ill-health and reducing the pressure on services.

Michael Matheson: Health inequalities and the illnesses that are driven by those are the result of social inequality so, very often, our health service is dealing with the symptoms of social inequality that manifest themselves in health inequalities. It is important that we take forward programmes such as reducing child poverty—through, for example, the Scottish child payment. All those will have an immediate benefit for the individuals concerned, but they will have a long-term benefit in reducing child poverty, which can result in health inequalities.

In addition, through the work that we do on tackling tobacco use, there have been reductions, and we want to continue to build on that. On alcohol misuse, a report that was published today by Public Health Scotland shows that minimum unit pricing has helped to reduce alcohol-related deaths by more than 13 per cent. All those factors play an important role in supporting us to prevent ill health, alongside our social policy actions to tackle social inequality. All that will be critical to supporting us in the preventive agenda in health.

Stephanie Callaghan: I am also really interested in how a focus on tackling inequalities in a shift to primary and secondary preventative care can ensure the financial sustainability of our NHS in the long term.

Michael Matheson: Earlier, I mentioned that the burden of disease over the next 20 years is projected to increase by some 20-plus per cent. If we are to address that, we need a very clear focus on prevention, to try to reduce some of that burden of disease—in particular, as our population gets older and people live longer. The measures that we take on prevention—the public health measures, the immunisation programmes, the screening programmes—all play a critical role in that. That requires action at both primary and secondary care levels.

There is no doubt in my mind that we have to make sure that we do as much as we can around the prevention agenda if we are to manage what will be a very significant increase in the disease burden that we will experience over the next 20 years.

Stephanie Callaghan: Just a very short final question—

The Convener: I am sorry. We do not have time.

Paul Sweeney (Glasgow) (Lab): Cabinet secretary, you mentioned that prevention is critical to controlling overall cost pressures on the NHS, yet the NHS in Scotland has the lowest share of preventative spend of any Organisation for Economic Co-operation and Development healthcare system. One way to address that is through the mental health challenge that this country faces.

In the 2021-22 programme for government, the Government committed to a mental health and wellbeing service for every GP practice and 1,000 new roles to support community mental health resilience. Despite health and social care partnerships planning for the roll-out of those services and the vital role that such community-based support provides in preventing mental health crises from reaching an acute situation, implementation has not yet started. Will you explain why that has not happened and why it has not been a bigger priority, given that it was in the programme for government?

Michael Matheson: Obviously, investing in mental health is a priority for the Government, and there has been significant investment over the past decade or so. There is a financial aspect to the specific workers that you mentioned. The biggest challenge is in managing all the competing demands within the NHS budget. Financial constraint is limiting our ability to run forward with the programme as it stands. When financing becomes available to us, we will be able to do so. You will be aware that we provide other projects in support, such as link workers, who are very valuable in GP practices and help to signpost people, including those who have mental health conditions, to other services. The principal reason for our not being able to take forward that programme is a lack of available finance for us to extend it in the way that we would have wanted to.

Paul Sweeney: I recognise your point that finance is tight, although you have a relatively privileged position, in that your area has the biggest expenditure by the Scottish Government, with a 6 per cent cash and 3 per cent real-terms increase in the projected budget for the next financial year.

We know that when we do not aggressively pursue opportunities for savings and prevention, we end up incurring costs somewhere else in the system. One area that we have identified in our discussions with chief executives is NHS 24, which has seen a 580 per cent increase in calls based on an annual rate of calls that are associated with mental health problems, and where dental health calls have also significantly increased, with 67,000 calls made in 2022-23 in comparison to just under 30,000 in 2019-20.

The pressures are visited elsewhere in the system, which seems unsustainable in view of those figures, which certainly shocked us when we heard them. Do you recognise that we need more investigation of where we can aggressively pursue opportunities for savings and push that prevention

spend because costs will otherwise be incurred elsewhere?

Michael Matheson: Our individual health boards have to meet a recurring 3 per cent saving target in order to try to free up resource to invest in other parts of the health service provision and to ensure that they are using their resources as efficiently as possible. I should add that they retain that money.

We could do many things with additional financial support. I recognise that I hold the biggest part of the public sector's budget but, as we have already heard, some boards are facing extreme pressures across a range of services. Choosing to put extra funding into the provision of mental health workers in GP practices involves taking money away from somewhere else. There is not a spare pot of cash to draw on—money has to be taken away from another service. Very few people ever say to me that I should cut money from this service and put it into that one instead because it is more valuable—all services are valuable and important.

We have committed to increasing the health service budget by 20 per cent this parliamentary session. We will continue to try to make as much use as we can of the investment that is available to us in order to maximise the benefits. I hope that if inflation comes down—although it looks as if it will not come down as quickly as we would want it to—and energy costs come down, we will see some of the financial strain that we are facing ease over the next couple of years, which will allow us to consider how we can flex some of that resource into other areas and front-line services in a way that we are not able to do at present. I hope that we will be in a position to do so, but we are also going through a period of public sector austerity, which is having an impact on our budgets.

Paul Sweeney: [*Inaudible*.]—your 20 per cent increase. One of the other commitments is for the mental health share of health spend, which is currently around 8.8 per cent, to rise to 10 per cent. We are kind of stuck on 8.8 per cent at present because, effectively, we have just had a restoration of the cut due to the emergency budget review. What is the push ahead to that 10 per cent target? Will we get there? What is your view on how achievable that target is?

Michael Matheson: Our intention is to get there, but it will be challenging to do so in the present financial environment. We will do what we can in this parliamentary session to try to get to that 10 per cent target. I do not have the clarity right now on what budgets will look like next year or the year after that—there is a level of uncertainty about that. However, that is certainly the target that we are aiming to deliver in this parliamentary session and there is no lack of desire to try to achieve it and to ensure that that investment happens in this session.

The Convener: I know that this is unusual, cabinet secretary, but would your diary be able to accommodate an extra ten minutes for the committee?

Michael Matheson: Of course.

The Convener: Thank you. In that way, we will manage to get through all our questions, provided that questions and answers are still concise.

I move to the next theme and call Tess White.

Tess White: Cabinet secretary, you mentioned the Baird family hospital and ANCHOR centre. Thank you for doing so—I am glad that they are at the top of your mind—but alarming concerns have been raised about delays as a result of issues with the water and ventilation systems, of which you are aware. I would like to hear your thoughts on how we make sure that lessons have been learned from ventilation and water systems in other hospitals, and on what you can do to oversee the matter to prevent any issues from arising at those two centres in the future.

Michael Matheson: I acknowledge people's concerns about the delays that have resulted from issues with the water supply and the ventilation system. If anything, though, the fact that those issues have been picked up demonstrates that lessons have been learned. The NHS assure service now has to sign off and approve a capital facility of that nature before it can be declared fit for use, and it has identified deficiencies and addressed those with the board. There are perhaps some lessons for the board with regard to how such a capital project should be managed and how it could possibly have avoided what happened, but the check system that we have in place has caught and identified the issue, and the appropriate measures will have to be taken.

As I have said, if anything, that demonstrates that we have learned lessons from previous experience of facilities that were about to be opened and problems that were identified. In this situation, the problems have been identified at an earlier stage in order to be addressed. Of course, that has resulted in some delay, and it would have been better if that had not happened in the first place. I expect us to look at what we can learn from NHS Grampian's experience in taking the project forward, but I am reassured that the NHS assure process has captured and identified the problem to prevent its being embedded even further at a later stage in the project.

The Convener: I call Paul Sweeney.

Paul Sweeney: I want to pick up on some of the maintenance backlog issues that we heard about

from the chief executives. For example, NHS Greater Glasgow and Clyde cited backlogs at the Inverclyde royal and Royal Alexandra hospitals of £100 million and £80 million respectively. I understand that most boards will allocate their resource based on which outstanding issues for repair pose the highest risk to patient safety. However, is it sustainable for boards to take that more reactive approach to addressing such matters by doing so only once they become a serious patient safety issue instead of their having a much more robust, preventative maintenance programme? What does best practice look like, and how can we help health boards move to a more preventative approach instead of their simply reacting to issues that could cause deaths?

Michael Matheson: Ideally, we would be in the position of trying to address as much of the backlog as possible to reduce the risk of its becoming a safety issue for patients or staff in a building, but the challenge that we face is that capital budgets neither provide for that nor allow us to achieve it. Boards work in a dynamic environment in which they address maintenance backlogs on the basis of priority, and some of that will relate to clinical safety purposes. They will continue to work on that basis.

Alongside the need to provide new facilities and deal with the maintenance aspect, there is huge pressure on our capital budgets. I expect boards to work dynamically to identify the critical elements that have to be taken forward and ensure that matters are being addressed efficiently and effectively so that they do not interrupt clinical services or cause safety issues. We continue to try to invest in our estate as we go forward, both in maintenance and in new facilities where necessary.

Paul Sweeney: The NHS Greater Glasgow and Clyde chief executive cited the particularly shocking example of the institute of neurological sciences in Glasgow, where the maintenance backlog has come at a human cost, with 17 incidents of patient death or harm in the past five years. The board has also spent £3 million on private surgery for patients, so it is clear that there is a business case for accelerating or expediting investment in that particular infrastructure, given the cost already associated with the backlog in terms of patient deaths and the cost of private provision to make up the difference.

There are also structural issues to address. NHS Lothian has stated that the Royal infirmary of Edinburgh's

"accident and emergency department was designed for a population of about 85,000"—[*Official Report, Health, Social Care and Sport Committee,* 6 June 2023; c 6.]

but it is actually seeing around "120,000 to 130,000" people coming through it, so the physical infrastructure is struggling to cope. Do you have a national risk register that you personally oversee to demonstrate where we need to prioritise capital investment, based on those metrics around patient safety and clear structural challenges? Is that something that is reported to you and on which you can take personal action?

10:30

Michael Matheson: No, that is led by boards directly, as they are close to the issues. For example, with the institute of neurological sciences at the Queen Elizabeth hospital, which you mentioned, the health board would be responsible for putting together a business case for additional capital investment in that facility. The business case would come to our capital allocations team, which looks at such issues and all the demands that come in from different boards. Again, the lead on such matters is taken by the boards, which know what their estates need and what the challenges are, and any business cases then come to the national health infrastructure board for consideration. Therefore, there is a mechanism for boards to utilise, as and when required.

On your second point about the challenges at Edinburgh royal infirmary, they reflect the fact that the hospital is now more than 20 years old and that a significant demographic shift is taking place in the country, with the population shift that we are seeing from the west to the east putting additional pressures on public services in the east of the country. That has happened over the past 10 to 15 years, and it is putting pressure on hospitals such as Edinburgh royal infirmary at the front end. Again, the board has the opportunity to look at putting together a business case for investment to expand that facility, and it would be for the board to lead on that and to submit a proposal for consideration alongside all the other health capital expenditure proposals.

Paul Sweeney: Are the boards moving quickly enough on those proposals to achieve cost avoidance? If you are going to expend on those capital programmes, will you avoid revenue expenditure? Are you pressing boards on the need to bring proposals forward more quickly?

Michael Matheson: Yes, but we must also keep in mind the fact that capital investment is a very expensive exercise to undertake right now, because of the huge capital inflation that we face. Construction inflation is running way ahead of standard inflation—it is up in double digits—so that has had a significant impact.

Our capital budget has been cut by around 5 per cent by the UK Government, which has had a direct impact on us. The value of what we have is less and buys us less, because of construction

inflation, so we must be very nimble on our feet and focused on how exactly we maximise the investment that we are able to make to deliver on the right capital investment projects. In my view, boards are not slow to flag up where they need capital investment and what that might look like. I would certainly never discourage a board from bringing forward a proposal but, equally, our boards understand the financial pressures that we are under, and things might not happen according to a timeline that they would ideally want.

Sandesh Gulhane: I am glad that you mentioned NHS Lothian, because there are some real issues with its acute mental health services. Patients have been lying on mattresses on the floor, because a unit that was designed for 105 patients has been coping with 129. There are no low-secure mental health facilities available in Lothian, even though there is going to be a big expansion in the number of people coming to Lothian. A proper rehabilitation facility and an essential low-secure unit will cost somewhere between £33 million and £61 million, while the cost of doing nothing is around £360,000; that also creates an issue for patients, who are being scattered around the country. Is the Government looking to help secure investments in capital projects such as this much-needed one in Lothian?

Michael Matheson: When a health board puts forward a business case for a capital investment project, it will go through the normal process in Government for considering proposals, but it must be set alongside all the other competing demands in the capital budget—a capital budget that, I should say again, has been cut. We have to balance it against the competing priorities in NHS Scotland and the different proposals from different boards. If the board brings forward a proposal, it will go through the normal process, but it will also have to be considered alongside all the other capital projects in NHS Scotland.

The Convener: That concludes our themed questions, but we have a couple of brief supplementary questions on other issues. I believe that Sandesh Gulhane has the first.

Sandesh Gulhane: Cabinet secretary, I have brought this point up before, both with boards and, indeed, the previous cabinet secretary, although not with you.

In NHS Greater Glasgow and Clyde—as in other health boards, but in Greater Glasgow and Clyde, in particular—there are information leaflets in many different languages, but Hindi is still not one of them. That is despite my having brought it up on a number of occasions. Why is that? Will you look to urgently chase that up?

Michael Matheson: I do not know why that is the case, and I am more than happy to have a look at the matter and respond to you directly on it. It seems a reasonable issue to raise and to be addressed, but I know neither the background to it nor the reason for it. I am more than happy to take a look at it and come back to you.

Sandesh Gulhane: Thank you.

The Convener: When the committee took evidence last week from the Scottish Ambulance Service's chief executive, I asked her—I should now declare my interest as a registered mental health nurse—about the impact of mental health assessment units and the redesign of mental health unscheduled care on the Scottish Ambulance Service. Today, the service wrote back to the committee to say that, in May alone, it has

"seen a reduction in patients conveyed"—

to A and E, I assume—of 50.2 per cent, and that

"The impact of this has reduced the overall service time and released 34 hours of crew-time in total back in to service".

That is before we look at the impact on patients being able to access appropriate services the first time they ask for them or more speedily. How can the Scottish Government and NHS Scotland continue to improve access to pathways for urgent and unscheduled mental health care and build on some of the gains that have already been made?

Michael Matheson: I think that that demonstrates the Scottish Ambulance Service's very innovative approach to providing services. The same applies not only to those services, but to the services that NHS 24 provides, with a significant amount of resource being made available to help support individuals who present with mental health issues. There has been a significant improvement in the service's performance in that area. In fact, the chair of the board was highlighting to me yesterday how mental health supports are a key priority as it moves forward.

We are seeing the Ambulance Service, in particular, becoming almost more of an outreach service in some ways, although that is probably not the best way to explain it. A see-and-treat approach is being taken much more often, in which the service provides direct interventions to patients there and then, instead of its having to convey them to an accident and emergency department or a mental health unit. That is an area where we want to see innovation and development continue.

The committee will be aware of the additional finance that we provided to the Scottish Ambulance Service to increase its recruitment, and that is another expanding area. Some of the

preventative work and support that the Ambulance Service can provide with regard to urgent unscheduled care are really important, and I think that that sort of approach will prove increasingly critical in helping to sustain and support our services. I absolutely want to continue to build on and progress that approach in both mental health and non-mental health settings.

The Convener: Thank you, cabinet secretary, for indulging the committee and giving us a little bit of extra time. It is very much appreciated, because it allowed us to get through all members' questions. I also thank the other members of the panel for their attendance today and their answers.

Decision on Taking Business in Private

10:38

The Convener: The next item on our agenda is to decide whether to take items 3 and 4 in private. Are we agreed?

Members *indicated agreement.*

The Convener: This is the committee's final meeting before summer recess. At our next meeting, on 5 September, we will undertake scrutiny of winter planning and preparedness in health and social care.

That concludes the public part of the meeting.

10:39

Meeting continued in private until 12:16.

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