OFFICIAL REPORT
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DRAFT

Health, Social Care and Sport Committee

Tuesday 17 December 2024

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
36th Meeting 2024, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Joe FitzPatrick (Dundee City West) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor Linda Bauld (Scottish Government)
Fiona Dill (Scottish Government)
Ruth Foulis (Scottish Government)
Alan Gray (Scottish Government)
Neil Gray (Cabinet Secretary for Health and Social Care)
Jenni Minto (Minister for Public Health and Women's Health)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 17 December 2024

[The Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 36th meeting in 2024 of the Health, Social Care and Sport Committee. I have received apologies from Elena Whitham.

The first agenda item is a decision on whether to take items 4 and 5 in private. Do members agree to take those items in private?

Members *indicated agreement.*

Budget 2025-26

09:30

The Convener: Our second agenda item is an evidence session on the Scottish Government's 2025-26 budget, which was published on 4 December 2024. I welcome to the committee Neil Gray, the Cabinet Secretary for Health and Social Care, and Alan Gray, who is the director of health and social care finance in the Scottish Government. I invite the cabinet secretary to make a brief opening statement.

The Cabinet Secretary for Health and Social Care (Neil Gray): Good morning, convener and colleagues. I am very pleased to be here to talk about the health and social care aspects of our proposed Scottish budget.

The budget sees record funding for health and social care, with more than £21 billion for the portfolio. The budget will help to deliver progress for Scotland's health and social care services, as well as lay the foundations for longer-term reform and improvement.

It is a budget for delivery that directly addresses the issues that people are most concerned about and that will support our services, ensuring that they are effective, efficient and sustainable. The budget will empower our reform programme to make those crucial services fit for Scotland's future.

The significant budget allocation includes an increase in our capital spending power of £139 million from 2024-25, as well as a commitment of almost £200 million to reduce waiting list numbers and delayed discharge. We will continue to focus on the reform and improvement of the performance of our services by deploying existing resources more efficiently and effectively, and we will continue to take decisive action to support delivery against the reform vision, which I outlined to the Scottish Parliament in June.

The budget will support measures to improve population health and early intervention preventative measures that will be delivered through effective primary and community care services. As such, we will prioritise and increase access to and capacity in primary care, including by supporting services in general practice, and we will enable the use of measures to sustainably treat more patients in community settings. That includes support for the expansion of hospital at home; immediate investment in general medical services to support critical services; general practice stabilisation and other primary care enhancements; additional support for general practice; a critical dental workforce and training

package; and a community eye care programme that will transfer patients from waiting lists.

Central to the operation of our health service are the health boards, which will receive more than £16.2 billion in total from the proposed budget. That sum includes funding to honour commitments to fair pay settlements for our health workforce.

As outlined in the budget document, our commitment to renew and reform our national health service means that we will seek to start work in 2025-26 on delivering a series of new acute care facilities.

The Convener: We move straight to questions.

Paul Sweeney (Glasgow) (Lab): I thank the cabinet secretary for his opening statement. Health and social care is a huge area of public expenditure for the Scottish Government. Next year, the overall health and social care budget is forecast to be 42 per cent of all Government revenue expenditure, which is a significant amount.

Understanding like-for-like comparators can be quite challenging; there are cash figures, real-terms figures and percentages. Our concern is that the change in baseline presentation in this year's budget presents challenges when trying to do a meaningful interpretation of year-on-year changes to the health and social care budget.

We note that, from budget to budget, there is a real-terms increase of 3.4 per cent, but under the new presentation of autumn review to budget, it is 7.5 per cent, which is a clear difference. Do you accept that the previous budget-to-budget presentation was more meaningful, given the significant in-year transfers that take place each year from health to local government and, in the case of clinical training, to education?

Neil Gray: I understand Mr Sweeney's question. It is a difficult situation. Whether it is in the health and social care budget or any other aspect of revenue and resource spending across Government, providing comparators can often be difficult, when in-year revisions take place because of Barnett consequentials or other in-year changes.

Obviously, we are looking for greater certainty on what our budget will be, which would be helped if United Kingdom Government spending reviews gave a greater trajectory towards what our financial allocations will look like. We also want to ensure that we have a stable budget that is balanced over the year. Due to the impact of austerity and spiralling UK inflation, we have had to make in-year budget revisions over the past couple of years, which we want to avoid doing this year. We want to give certainty to the system about what is coming forward.

With regard to providing clarity and detail, we are more than happy to provide written confirmation after this evidence session on the points that Mr Sweeney raises about the comparisons between one budget and the next or, indeed, between autumn budget revision and budget positions.

Paul Sweeney: That would be really helpful. If transfers are known about and tend to take place year on year as a common practice in Scottish Government financing, would it make more sense to show the budgets from the outset in the portfolio area that will ultimately undertake the spending? For example, that could be local government in respect of social care budgets or education in respect of nursing tuition.

Neil Gray: With regard to social care, we have set out in this budget the very clear transfer that is taking place between my portfolio and that of local government to increase the baseline level for social care provision. That is a pretty good story to tell. We have increased social care spending by 25 per cent, as was committed to two years ago. In fact, we have gone beyond that. We are spending an additional £350 million beyond the 25 per cent increase, which takes the health and social care budget commitment on social care to £2.2 billion. That is important, given the impact that delayed discharge has on the whole system and the need for us to have a whole-system approach to ensure that we have a smooth process for patients who seek to navigate it, which we will probably come on to talk about.

Again, if more detail is required by the committee on such known transfers, either in the budget or the budget documents, I am more than happy to provide that in writing, so that you get clarity.

Paul Sweeney: That would be welcome.

Does the cabinet secretary remain committed to the Scottish Government policy to pass on all health-related Barnett consequentials to the Scottish health budget? To what extent will that support the current 2024-25 budget?

Neil Gray: The short answer is yes, and the long answer is that we have gone beyond that. The funding that we have raised from our more progressive income tax policy means that, this year, we have £1.7 billion more resource to allocate to public services. That means that we are able to invest across Scottish public services to a greater extent than if we had followed UK spending plans.

Again, I am more than happy to provide additional information, but the policy remains that all consequentials for health are passed on in full.

Paul Sweeney: Could the cabinet secretary provide more detail on the changes that underpin the significant decline in the "miscellaneous other services and resource income" budget line?

Neil Gray: Yes, I am happy to provide that in writing. That budget line is used to ensure that flexibility is available across the year. I cannot remember the exact reason why there has been a reduction, but the overall position for the health boards that we fund is clearly up.

Perhaps Alan Gray can provide more detail.

Alan Gray (Scottish Government): There will be a correction to that when we publish the spring revision to the budget statement. That will correct the miscellaneous budget line, which is there to acknowledge the funding that we have without fully reflecting it. The spring budget revision will adjust and bring that into line, so the miscellaneous budget will disappear from that level and move above the line.

Paul Sweeney: That is helpful. Is it still the intention of the Government to increase direct investment in mental health services by 25 per cent over the course of this parliamentary session and to allocate 10 per cent of NHS front-line expenditure to mental health?

Neil Gray: Yes, that is still where we seek to go. From a cash perspective, we have provided an increase to mental health spending. As Mr Sweeney outlined, there are two areas: the direct spending that is provided by Government and the service provision that is provided by our boards. We are confident that the investment that we are providing via our boards, as well as from Government, will ensure that we meet the needs of the people of Scotland.

Of course, there is a significant area of challenge, particularly after Covid, in people who present with increased and more acute mental health issues. That has been particularly stark in child and adolescent mental health services; however, particularly in those services, there has been a good story to tell for Government and boards, in that there has been a significant reduction in waiting times, and significant investment. Funding has doubled and there has been a near 50 per cent increase in staffing over the period, which has resulted in greater capacity.

Issues still exist in regional areas, and we are working with them to ensure that they meet the wider Scottish standard. The most recently reported figures on child and adolescent mental health services are the best on record and have provided a significant improvement on where we have been, which is a good news story.

We have issues with consultant psychiatric staffing. In those areas, we are working with NHS Education for Scotland in an attempt to provide the required capacity for acute in-patient support as well as support for general practices to provide mental health support from our community mental health practitioners.

There is a range of intervention in the mental health space, because we recognise that it is a growing challenge. That is borne out from the most recent census data, which demonstrates the challenge that people feel with their mental health.

Paul Sweeney: The cabinet secretary is right to point out a real crisis in mental health in the country, with the rise in general issues. He also pointed out that the Government's stated objective was to increase the overall percentages of mental health investment, yet the 2025-26 budget shows a 1.1 per cent real-terms cut to the mental health services budget line. That comes back to the cash versus real-terms issue, as well as where you measure from—budget to budget or autumn review to budget. Certainly, when we look at the 2025-26 allocation compared with the 2024-25 budget—not the post-autumn budget review figures but from budget to budget—we see that the mental health services budget faces a cash cut of £20 million. How does it marry with the Government's stated intention to grow the overall slice of the NHS budget pie that goes to mental health, when that is actually going backwards?

Neil Gray: I will bring in Alan Gray in a second to provide more detail on that. First, I note that I did not use the words that Mr Sweeney used to describe the situation on mental health services. I said that there is a challenge, and I want it to be clear that I recognise that there is a challenge. For some people who are waiting too long to access services, Mr Sweeney's description would be apt, but that picture is not faced by everybody in the system, nor is it faced by every mental health practitioner—although, again, I understand that those practitioners who are under pressure will recognise the description that Mr Sweeney used.

I will bring in Alan Gray now to determine issues around the budgetary situation.

Alan Gray: It is not an actual decrease in the budget. We have put more money into board baselines. It does not show as a separate line in the budget, but it is in the health board line. For a number of areas, including mental health, we have been moving more and more money into baselines—to give boards certainty of funding and allow them to make long-term or medium-term plans to invest in services and deliver the outcomes that we are looking to deliver.

Again, I will be happy to provide a clarification after the meeting on a number of areas in which we have increased baseline funding. Perhaps it

looks like a drop in individual lines in the budget, but that is not the case.

09:45

Paul Sweeney: Where the Government has set clear missions—a 25 per cent increase in direct investment in mental health services and 10 per cent of NHS front-line expenditure being allocated to mental health—it would be really useful to know exactly where the Government is in meeting those targets.

Neil Gray: There is progress on both, and we are happy to set that out in a letter to the committee after this session.

Paul Sweeney: Thank you very much.

The Convener: We have a couple of supplementary questions on this theme.

Joe FitzPatrick (Dundee City West) (SNP): Cabinet secretary, you will be aware of the Audit Scotland report that suggested that there was a lack of a clear plan to deliver the Government's vision. How does this budget fit in with that, and how does it help the Government to deliver its vision for the NHS in Scotland?

Neil Gray: I acknowledge the Audit Scotland report, and we will work constructively with the Auditor General on the findings that are contained in it.

In June, I made a statement to the Parliament, setting out what my vision for health and social care services looks like and what reform and improvement need to deliver. I think that all of us around this table, across the Parliament and across health and social care services recognise that there is a need to shift the balance of care from our acute hospital settings into primary and community care services. This budget continues that process. It provides increased spending for general practice, a substantial increase in funding to primary care services in general, including ophthalmology, and more capacity for dental services and pharmacy. It also seeks to ensure that we utilise the capital and resource funding that is available to us to make use of innovation that is coming on stream.

As part of the national conversation, last week, I met the Health and Social Care Alliance Scotland-led stakeholder advisory group that is helping us to capture patient voice. I have regularly met our royal colleges and trade union representatives, including the British Medical Association, on recognising clinical voice. We will continue to meet academics and others so that the national conversation is on-going.

We all understand what needs to happen. There needs to be a shift in the balance of care: we need to ensure that we treat people earlier, prevent ill health, stop people's ill health progressing into the hospital setting and keep them at home for as long as possible. There is much in the budget that helps to achieve that, including the expansion of hospital at home and support to free up our hospital services through investment in social care to prevent delayed discharge.

As I set out in June—in direct response, I think, to a question from Sandesh Gulhane—the challenge was around how we do this; how we shift the resource that is needed into primary and community settings without detriment to our secondary care services. We are all engaged in trying to deliver that. This budget starts the process, and I am very pleased that we are able to start making progress, because we need to ensure that we deliver a sustainable, productive and efficient health service that meets the needs of the people of Scotland.

Brian Whittle (South Scotland) (Con): Good morning, cabinet secretary. In answer to my colleague Mr Sweeney's question about the allocation of funding, you touched on the fact that, sometimes, the way that funding is allocated makes it hard to see where it goes. That is one of the main criticisms. In such a huge budget, it is very difficult to follow the money. Is it not about time that we got to a position where we understand where the money is spent? It cannot be right that £21 billion of public funding goes into the NHS, and we do not know where it has gone.

Neil Gray: I thank Mr Whittle for his question, and I understand where he is coming from. There is a balance to be struck around allocating fixed pots of money towards particular areas of investment. Mr Sweeney's question was particularly directed towards mental health services, which I understand, but we must also ensure that our boards that deliver those services have the certainty of on-going, multiyear funding. That is where Alan Gray's point around baselining is so important.

The situation is similar for drug and alcohol services, which we have given an additional £19 million of baseline funding to provide greater certainty to those who provide the services—through employment contracts for new staff, as opposed to providing short-term contracts. Those services provide certainty and additional baseline funding, and the providers know that that funding will be recurring, which will allow them to invest in more sustainable services.

I understand the premise of Mr Whittle's question. I will follow up in writing to give clarity on where we envisage the funding going, which will be helpful to him because it will demonstrate that the funding is going to front-line services, delivering a more efficient and productive system

and ensuring that those who deliver our front-line services have greater certainty on what they can invest in—this goes back to Mr Sweeney's point about providing certainty through our budget—based not just on one year's budget but on multi-annual funding. That will allow services to invest in clinics and projects over not just the short term but the longer term.

Emma Harper (South Scotland) (SNP): Good morning. The overall budgets of some territorial boards are increasing in cash terms by 14.2 per cent, but some—including NHS Borders, NHS Dumfries and Galloway, NHS Highland, NHS Orkney and NHS Shetland—are receiving increases in their budgets above 14.9 per cent. I am interested in the decisions that were taken to increase the budgets for those territorial boards. Were they taken to support reductions in waiting lists, to address delayed discharge and to address other aspects?

Neil Gray: Yes, they were taken to address all those things. I thank Emma Harper for her reflection on the investment that we are making in predominantly rural and island boards. The national resource allocation committee formula recognises the increased challenges and costs that are associated with delivering services in those areas. Ensuring that the funding allocation for every board in Scotland is within 0.6 per cent of the NRAC formula ensures that there is parity across all boards and that boards that have challenges in delivering services, predominantly in rural and island settings, are able to deliver them. The discussions that I have had with board chairs and chief executives show that there is enthusiasm about what they can do with the increased funding and what they can deliver.

I have clear priorities on expanding primary care and general practice, in particular, and on reducing delayed discharge and waiting times. Those are clear areas of investment in the budget, because I recognise that that is what people need to see from health and social care services in the coming year. We have put our money towards our priorities.

Emma Harper: My understanding is that the NRAC formula, which you mentioned, is under review and could be altered. Where are we with that? When will the findings be ready to be published, for instance?

Neil Gray: The formula is under review, and we continue to review it. It is a very complicated financial system, and unpicking it could have unintended consequences, so we need to ensure that, if we change it in any way, we deliver improvement rather than detriment.

I do not have a timescale for when we expect to publish any commentary on the NRAC formula or reach a decision on whether we change it. The important principle in the budget is that the budgets for all boards are within 0.6 per cent of the NRAC formula, so there is no detriment to any territorial board across the country. All of them have parity in being able to deliver services, and we will keep the NRAC formula under review.

Sandesh Gulhane (Glasgow) (Con): Good morning. I declare an interest as a practising NHS general practitioner.

Cabinet secretary, you previously said:

"The funding outlined will support NHS reform and our efforts to improve population health with a focus on prevention and early intervention."

Today, you said that the budget empowers reform, but the budget line for improving outcomes and reform has been cut by 21 per cent. How does your statement stack up with that cut?

Neil Gray: That ignores the £200 million in the budget that is allocated to waiting times improvement and improvement in capacity in relation to delayed discharge. Those budget lines—the £200 million—are not just about meeting immediate need and delivering capacity; they are also about working with boards to have a sustainable service delivery model that means that they provide health service and social care capacity on a sustainable basis. That is about reform and improvement, as well as meeting the immediate demand that we all know exists for us to address waiting times and delayed discharge.

The point that Mr Gulhane makes ignores some of the investment that is being made elsewhere in the budget.

David Torrance (Kirkcaldy) (SNP): What further action is required to achieve financial stability in the health service, and over what timescale is break-even now envisaged? Does the cabinet secretary expect any of the boards that are at stage 3 in the performance escalation framework to be de-escalated in the coming year?

Neil Gray: In spite of our investing a significant amount on a record increase to bring health and social care spending to record levels, there are challenges remaining, and there will be boards that continue to face financial challenges. The financial delivery unit will keep working with them, and we expect those that are on the escalation framework to continue to progress towards becoming more financially sustainable.

I have a number of points to raise. Providing greater certainty over funding allows for longer-term planning; I made that point in response to questions from Mr Whittle and Mr Sweeney. Bringing down the level of demand, particularly on secondary care services, and shifting the balance of care into the community, will be of critical

importance to achieving greater financial sustainability in health and social care services.

Improving the health of our population is also critically important. I made the point on "The Sunday Show" with Martin Geissler that one of the most important things that individuals can do to take responsibility is to take advantage of the vaccination programme, if they are eligible for it. It is good for people in terms of preserving their health, but it is also good for the health service because it reduces the demand that arises from, in this case, respiratory conditions such as flu, respiratory syncytial virus and Covid, which tend to spike at this time of year.

We continue to invest in breaking down barriers to people looking after their own health and wellbeing better. That comes through the likes of the community link worker network, as well as the investments that we are making in sport, physical activity and wellbeing, and the impact that the culture budget spend will have on our health and wellbeing, particularly our mental health. As a former culture minister, I know that that expansion is good in its own right, but it also has the opposite impact to what happened during Covid, when not being able to go out and experience culture and leisure services had a clear and demonstrably detrimental impact on people's mental health. Expanding provision and increasing access in those areas can have a virtuous and positive impact. A number of areas that are outside the health budget help to improve our health and wellbeing.

Finally, we are making investments to reduce child poverty on a wider Scottish budget and cross-portfolio basis. Poverty is one of the greatest drivers of ill health and health inequality. By addressing child poverty, we can also increase the health of our population and reduce demand on our health services. I can therefore point Mr Torrance to a number of areas that help to make our health service more sustainable.

David Torrance: How achievable is a recurring savings figure of 3 per cent considered to be for NHS boards?

10:00

Neil Gray: I accept that that will continue to be challenging, but it is important that we continue to push for maximum efficiency and productivity in our health service. We need to make sure that every penny and pound that are invested go as far as possible. That is why we have the national conversation, through which we are working with our clinicians—to ensure that reform and improvement are clinically led and managerially enabled—and which is about reducing the areas of low clinical benefit.

It is about making sure that we successfully deploy polypharmacy reviews. We know that the cost to the health service of people who are on multiple prescriptions—10-plus prescriptions—is about £350 million a year. A lot of work is going on to reduce the potential harm that can come from that. Polypharmacy reviews are important in reducing prescribing rates and making sure that we continue to practise realistic medicine in delivering better outcomes for patients. Those are some of the areas that boards can look to and that are in the 15-box grid that we provide to them.

It is also about more positive innovations, rather than feeling that service detriment can come from such decisions. It is about embracing innovation—a point that I know Mr Whittle is particularly interested in—and making sure that we free up greater clinical capacity to deliver the parts of care that can be delivered only by humans and the care, compassion and loving approach that our clinicians deliver. There is a range of areas that our boards can look to.

I recognise that delivering recurring savings will continue to be challenging, because we have asked boards to do that in recent years, too. However, as Mr Whittle said, it is vitally important for the public to be able see the £21 billion budget being delivered as efficiently and effectively as possible and delivering the greatest bang for its buck.

David Torrance: How might multiyear settlements assist in achieving financial stability, and what are the barriers to providing such settlements?

Neil Gray: Mr Torrance is absolutely right to raise the issue. Multiyear settlements for Government would be incredibly helpful, and I hope that the spending review will deliver greater certainty for us. However, as I said to Mr Whittle and Mr Sweeney, I recognise that that is also incredibly important for our boards and for our community and voluntary sector partners, who help to deliver services. We want to do more in that area. In the proposed budget, we have baselined more of our budget and have provided greater certainty for mental health services, as I have referenced, and for alcohol and drug partnerships.

That is exactly what Mr Torrance is asking for and suggesting would be right for our public sector. I hope that I gave a pretty detailed answer to Mr Whittle on why that is important. However, certainty on the majority of our funding, which is the block grant, is the greatest barrier to that. The more certainty that we have on that front, the better. In that regard, I pray in aid the capital position. We have had increased capital investment from the UK Government for this year, but our longer-term trajectory makes it difficult for

us to have certainty on the multiyear position. When you are building a hospital, in particular, or with other capital infrastructure projects, you need multiyear certainty, because capital investment is required on a multiyear basis.

I hope that that gives Mr Torrance clarity on why providing as much certainty as possible beyond a one-year budget settlement is so important.

David Torrance: Thank you, cabinet secretary. I have no further questions.

Emma Harper: I have a supplementary question. I want to give an example of sustainability or supporting people to avoid hospital admission. Folk with chronic obstructive pulmonary disease or asthma can be helped to improve their lung health by going to a local choir, for instance. We know that that helps with pulmonary rehabilitation. How do we recognise the importance of, for instance, the third sector, in helping COPD patients or people who need lung rehabilitation to avoid admission to hospital?

Neil Gray: Emma Harper is absolutely right. Looking at the health budget in isolation misses the cross-Government impact on, and contribution to, our health and wellbeing. She pointed to the example of a choir, and various organisations do incredible work for people that would not ordinarily be seen as a health intervention but which clearly is. I am thinking of Scottish Ballet's work, which I was able to see when I was culture minister, as well as that of a number of cultural organisations that help with our physical health and wellbeing.

Community and voluntary organisations do incredible work in our communities. I am thinking of the national mission to reduce drugs deaths. In particular, there are phenomenal organisations that support individuals who have a drug dependency and their families. Those organisations are able to reach parts of our community that statutory services are unable to reach. There is a range of other interventions across various specialties, including cancer charities that do incredible work to support individuals. Those organisations provide a level of service that goes above and beyond what is provided from a statutory perspective.

I am clear about my appreciation and understanding of the central importance of our community and voluntary organisations; they supplement and add value to statutory interventions, and they can deliver services in an incredibly efficient way. I am very appreciative and cognisant of their impact. Since I have been health secretary, I have always encouraged our boards to continue to support community and voluntary organisations so that they can support the work that, as Emma Harper pointed out, makes a difference in individuals' lives.

Gillian Mackay (Central Scotland) (Green): Within the constraints of limited resources, how can the twin pressures of increased pay and demands for additional staff be balanced in the NHS and social care?

Neil Gray: That is a challenge. We need to ensure that we fairly remunerate our incredible staff and that we incentivise people to choose careers in health and social care even when some of their skills could be deployed in other parts of the public sector or the economy.

I am very proud of the fact that we have provided pay deals—not just this year but in previous years—that mean that, for the majority, our health and social care staff are the best paid in the UK. We have made sure that our consultants are paid competitively compared to consultants in other parts of the UK, and we have matched UK pay review body recommendations for many, including our general practitioners.

Ms Mackay is right that balancing that to ensure that we deliver service sustainability is an important consideration. However, we need staff, including front-line staff, to be able to deliver against the clear objectives that I have set out in relation to the budget. Those objectives are: to reduce delayed discharge, which means increasing social care capacity; to increase the accessibility of primary care and general practice; and to reduce waiting times. We will need to buy greater provision, which means greater investment in staff. There is always a balancing act to be done. That is why we have set out clear support to our boards around the 15-box grid that I referred to in order to achieve recurring financial savings and service improvement to maximise the capacity of clinicians and staff and so that the productivity and efficiency of the system are sound.

The utilisation of innovation to free up clinical time and the advent of the theatre utilisation tool, which is delivering 20 per cent increased efficiency in our theatres, represent more examples of how we can ensure that every penny and every pound that we invest in the health service go further. That helps to ensure that the investments that we are making in our staff, which I am proud to make, can continue and can be sustainably achieved in the future.

Gillian Mackay: The Scottish Fiscal Commission identified a risk that the budget does not account for the recent rise in national insurance contributions. How will the Scottish Government ensure that health boards can manage that uncertainty without compromising critical services? If the compensation that is provided by the United Kingdom Government does not match the estimated cost for national health service boards, are there strategies in place to address that funding gap?

Neil Gray: Gillian Mackay points to what I think is the greatest risk that we have in the coming year, not just in health and social care services but across the public sector, and that is the impact that the rise in national insurance contributions will have.

We do not yet have clarity or certainty about what that impact will look like. We know that, across the entirety of the public sector, including people who are contracted to deliver public services, such as GPs, social care providers, dentists and people in the community and voluntary sectors, the cost to Scotland will be approximately £750 million. We have had an indication from the UK Government that it will cover somewhere between £290 million and £350 million, which means that we will have an immediate substantial deficit of £400 million or more.

The funding that has been suggested thus far by the UK Government is only for those who are directly contracted in our public services; it does not cover people such as GPs and social care providers and people in the community and voluntary sectors, universities and so on. We face a substantial risk. We know from social care providers, including some GPs that I have spoken to, that the rise represents an existential risk for some of them.

The UK Government has rightly sought to raise revenue, but I do not believe that it understood the implication of choosing to raise that revenue from employer national insurance contributions. That is evidenced by the fact that we still do not have clarity in terms of what it describes as the mitigations relating to the damage that the move will cause. It could have chosen other ways of raising the revenue that is required to start to unpick austerity. It made the wrong choice, and that will have potentially catastrophic implications for not just health and social care services but public services in Scotland and across the UK. That is why I hope that committee colleagues will unite with the Scottish Government in saying that the issue must be quickly resolved at source by the UK Government, so that we can provide certainty to those employers—our GPs, social care providers and so on—that are seeking to make employment decisions right now but have no certainty about what their national insurance position is going to be.

Gillian Mackay: The cabinet secretary was on the same panel as me at a Scottish Care event where we heard that the impact of the rise could be as much as £300,000 for an individual care home.

Are any particular measures being taken to ensure that GP practices and third sector providers that fall outside that direct public sector boundary are not disproportionately impacted by the increased national insurance burden?

Neil Gray: Some of those providers will be disproportionately impacted because of the nature of the route that has been chosen by the UK Government, such as those with a higher number of staff who are paid at a lower salary rate.

One of the other issues that I believe is going to be problematic is that those who are contracted to provide more than 50 per cent of their business within the public sector will not be eligible for some of the relief that the UK Government has proposed. That, again, serves to illustrate to me that the move has not been properly thought through and that the UK Government has chosen the wrong area from which to raise revenue.

Again, I underline that the UK Government should raise revenue to invest in public services to start to undo the damage that austerity has done. The revenue that has been provided to the Scottish Government through the budget is very welcome—it starts to make progress. It does not answer all the questions from the Scottish Government or, indeed, other Governments. I genuinely believe that the UK Government went down the wrong route on raising revenue and that there will be clear and stark unintended consequences that it will have to resolve—and quickly.

10:15

The Convener: We are rapidly running out of time and we still have lots of questions to get through. I ask committee members and witnesses to be concise with their questions and answers.

Neil Gray: I will attempt to be pithy, convener.

The Convener: I will try to lead by example. I put on record my entry in the register of members' interests: I am employed as a bank nurse by NHS Greater Glasgow and Clyde.

What is the planned total level of spending on social care for 2025-26, and which specific budget lines contribute to that overall figure?

Neil Gray: I have set out the £2.2 billion allocation in the health and social care portfolios. The wider Scottish budget will take social care provision to almost £6 billion—across the wider spend that is contributing to provision—but the direct funding that comes from my health portfolio will be £2.2 billion.

The Convener: How does the Scottish Government agree the appropriate balance of spending between the health budget and the social care budget?

Neil Gray: That is a very good question. That is done by negotiation and discussion and by

recognising where demand will be. By the way, the £2.2 billion that is coming from my portfolio is an increase of £160 million—I think—that will go into social care. That is taking us beyond the commitment that we made previously to increase social care spending by 25 per cent over the course of this parliamentary session. We have gone beyond that by £350 million. The allocation comes through discussion, predominantly between the finance secretary, who also has responsibility for local government, and me. As I and Alan Gray have set out, there is an increased baselining of local government funding to include social care spending. I am happy to provide greater clarity on that in a follow-up letter.

The Convener: The committee has taken evidence from integration joint boards over the past couple of years. We have looked at their budgetary requirements and their concerns about budgets. To what extent is the Scottish Government willing to consider direct funding to integration joint boards in the future in order to further improve transparency and effective planning?

Neil Gray: A number of conversations are on-going with local government and health boards around social care provision and national care service reform. We have obviously paused stage 2 of the National Care Service (Scotland) Bill to allow for consideration among political parties, as well as discussion with local government. We are looking at what is possible in the budget, with the £100 million that is there, to improve the picture in delayed discharge. I expect a substantial amount of that funding to go into social care provision and to arrive at IJBs in one way or another, whether that is through health boards directly or through local government.

We recognise that we need reform and that we need to improve financial transparency and accountability, and to take account of the service user and carer voices in the process. All those matters are part of our discussions and considerations with local government and other political parties about the next stage of the National Care Service (Scotland) Bill and how we will deploy the £100 million that is there to improve the delayed discharge picture.

Carol Mochan (South Scotland) (Lab): I want to ask a wee bit about capital investment. The Scottish Government previously said that it intended to publish a capital investment strategy for health. Do you have any clarity on when that might happen?

Neil Gray: We are looking at a wider cross-government infrastructure investment plan, to be delivered after the UK Government's spending review in the spring. Once we—as we hope we will—get multi-annual funding and greater certainty around the capital position, that will allow us to have greater certainty around our capital plans.

I and others across Government wanted to make sure that we are able to take forward capital projects and to lift the pause on health capital spending. That has been illustrated through the investment in the Belford hospital, the eye pavilion and Monklands hospital. Monklands is in my constituency, so I am recused, from a Government decision-making perspective. Those are important areas of investment that we need to take forward. The capital investment that comes through the budget allows those projects to progress, but the big decision-making points will come after the UK spending review and publication of the infrastructure investment plan thereafter.

Carol Mochan: That is helpful to know. During those discussions, will we get some clarity about the pause on the national treatment centres? Is that something that you are considering?

Neil Gray: Yes. All potential capital projects that have been on the stocks will be part of that consideration, as well as anything new that has come through. Clarity on all that will be provided at that time.

Carol Mochan: I know that time is tight, so I will quickly ask about two areas that have been discussed before that need thought around capital investment. The first is reinforced autoclaved aerated concrete in NHS buildings. Do you know where we are with that? To the best of your knowledge, will that be addressed?

The other area is the commitment to net zero in the health service. That really changes things for the health service, and is an important aspect of it. How do you feel that capital investment on that will go this year?

Neil Gray: In the interest of time, I will provide the answer to the RAAC question to the committee in writing. We are aware of the situation in the health service and we support boards in relation to the immediate mitigations and the remedial works that are required.

I take the issue of net zero very seriously. It can be both a capital and a resource revenue investment opportunity. Again, I would be happy to provide in writing some information on the areas that we are looking at. I am exploring that issue right now, particularly on the revenue side, and I would be happy to provide more detail in writing to the committee, when that can be published.

Carol Mochan: Thank you.

Emma Harper: I have a quick question about digital and innovation. Earlier, I spoke about pulmonary rehab, which I know is being delivered remotely, which is good for rural areas. I would like

to hear from you about artificial intelligence and how it will link to the budget in the future.

Neil Gray: We are adopting innovation that is coming through the academic sphere, the private sector and our staff. There is incredible innovation, particularly on clinical pathways and clinical governance, to do things in a more efficient way. Our staff are doing fantastic work there, including through the skill projects and the Scottish infection prevention and control education pathway.

AI provides a particular opportunity, as does the digital side. We have already seen the beneficial outcomes of that from a radiography perspective in the cancer space. We need to make sure that we get that right, and that we do it in a safe and ethical way, but I go back to my earlier point about embracing innovation that can free up clinical time, so that our clinicians can deliver more human-to-human caring, which is so important.

The chief scientific officer for health, Dame Anna Dominiczak, is working incredibly hard in the Triple Helix Group, which brings together industry, the health service, Government and academia to make sure that our health service and our economy get the maximum benefit of the innovation that is coming through.

I point the committee to Dame Anna's work as something that addresses some of Emma Harper's queries. There is a huge opportunity before us, and I am determined to ensure that our health service is better able to embrace and support the innovation that is coming through and those who are investing in innovative technologies so that they can be adopted more quickly in the health service. That involves a cultural shift, as well as a practical and structural shift, in the way that the health service operates. I am, however, determined to do that, because I cannot see us having successful reform and improvement without adopting greater innovation. It has to be central to the plan.

Emma Harper: Thanks.

Brian Whittle: You will not be surprised to hear that many of my questions will be focused on prevention and a whole-systems approach. Once again in the budget, we see a cut to sportscotland's budget and a cut to active healthy lives funding, which seems to have been a consistent theme throughout my time in the Parliament. That is at a time when we do not have a good health record in Scotland; indeed, it is increasingly poor. Do you not recognise that cutting the opportunities that are available to our young people and to the public in general only increases the strain on our medical centres, hospitals and general practitioner surgeries? Is it not time that we took preventative health seriously?

Neil Gray: I do take that seriously, and I recognise why Mr Whittle raises that question. He has a far more illustrious athletics background than I do. My athletics career was cut short although, even still, I do not think that I would have been as fast over 400m as Mr Whittle was.

Seriously, I very much recognise the point that he is making. I want to make sure that the opportunities that were afforded to us to access sporting and leisure services are afforded to my children. I have set out to colleagues across the committee my recognition of the impact of investment that is beyond what we would deem to be health and social care spending and is preventative. That can be in our sporting and leisure facilities and in our cultural estate. I recognise the point that the member is making.

I will come back to Mr Whittle on the active healthy lives funding and the sport funding, so that he gets greater clarity on our intention and how we are providing support to sporting organisations and those who provide the phenomenal opportunities that exist across the country. That is something that he and I witnessed at the most recent sports awards, where we saw incredible dedication, from community and grass-roots level, right up to elite level in Scotland. We should be incredibly proud of that and continue to support it.

I will provide more information for Mr Whittle on that.

Alan Gray: As I said, we can provide a written statement to set out how the budget has moved over the past few years and where it has gone.

Brian Whittle: The information that we have is that sportscotland's funding is down by 2.3 per cent in real terms, and active healthy lives funding is down by 2.3 per cent. I recognise that you share an interest in getting our population active, cabinet secretary, but the reality is that, as the health budget has increased in proportional terms, at the same time, the proportion of investment in local councils has decreased and the health of the nation has decreased. The cabinet secretary recognises that many of the solutions to our poor health record in Scotland lie outside the health budget, because a lot of them are delivered by councils.

Do you recognise that there is a huge reduction in the opportunity that is available to our population because of the closure of many facilities and the decrease in physical activity opportunities in our education system?

Neil Gray: In the 35 seconds that I have available, I will agree that we need to shift to a more preventative model. We have provided a real-terms increase to local government, with more than £1 billion extra in the budget.

10:30

I recognise that, as is the case with the health budget increase, there will still be pressures across local government—of course there will be. We have had a decade and a half of austerity that has eroded the potential for investment in our public services. However, the 2025-26 budget directs funding to public service investment for exactly the reasons that Mr Whittle has set out. I very much recognise the extent to which health is affected by many other portfolio spending areas. Mr Whittle gave the example of the role that local government plays in providing leisure facilities and sporting facilities. I hope that the budget will help to support those facilities and that the impacts that he has suggested will occur are not an inevitability, because of the investment that we are making.

Brian Whittle: I have a final question. We have moved away from a situation in which, roughly speaking, a third of the budget went to health and a third of it went to councils. Obviously, the health budget has increased dramatically, while the local government budget has decreased dramatically and health outcomes have become increasingly poor. I have talked about preventative health in the Parliament for the best part of a decade, and the situation has not improved.

The cabinet secretary says that he is keen to move towards a preventative health agenda, but one of the issues that we face is the lack of data to measure progress in that respect. How will the Scottish Government measure the impact of a preventative health agenda on the Scottish population?

Neil Gray: Measuring prevention is, by its nature, difficult, because it is difficult to know what you have stopped happening.

However, I recognise Mr Whittle's point. We can look to a number of areas. For example, we are working with the British Medical Association on how we can get more data through from general practice. Primary care is where the bulk of the preventative activity in health spending occurs. Because the provision of primary care is contracted, it is difficult to have a clear picture of where improvements are happening. That said, according to the most recent figures that are available, the number of GP appointments has gone up substantially. In October, there were 8.3 million interactions across the entire multidisciplinary team in general practice, which represents an increase of almost 900,000 on the previous month. The number of such interactions has gone up by a substantial amount year on year.

We know that the level of engagement has increased and that we need to increase capacity. We need to work with the BMA on how we can record what those interactions are doing so that we can have a greater understanding of what they are preventing. That is what Mr Whittle is asking for, and I know that the BMA is up for that and that it wants to continue to provide the answer to those questions.

A huge amount of work is being done by the chief medical officer, along with clinicians, on cardiovascular disease prevention. That is an area that we are seeking to prioritise this year, for all the reasons that Mr Whittle has set out.

Brian Whittle: Surely prevention is about reducing the need for people to seek medical interventions.

Neil Gray: Yes, I absolutely recognise that, but my point is that, when someone does not need an appointment, it is difficult to understand whether they would have needed an appointment in the first place.

Our preventative activity is about reducing the overall level of interaction with secondary care services, in particular. We want to reduce the level of acute admissions and to stop the escalation of people's ill health. All that is wrapped into what we are seeking to do in the budget, especially with the £200 million that we have set aside for reducing waiting times, addressing the efficiency of flow in the system and reducing delayed discharge. That involves providing capacity to our social care providers and our primary care providers.

The issue is not only about general practice. We have a huge opportunity with ophthalmology in the community and from encouraging greater utilisation of our pharmacy first programme. A range of interventions are available. However, I again point to the fact that not all prevention will be achieved through health service intervention. Mr Whittle and other members have spoken about the importance of our sporting and leisure facilities, as well as that of cultural and other public service interventions.

Brian Whittle: If you measure obesity levels, type 2 diabetes levels and other such issues, I would have thought that that would give you an answer.

The Convener: Carol Mochan has a supplementary question.

Carol Mochan: I want to ask about alcohol and alcohol harm. It has never been more urgent for the Government to devote sufficient resources to enable the development of a coherent plan of action to prevent people from suffering from the many and varied harms of alcohol. At this stage, it does not feel as if the budget will provide for that. Will the Government commit to looking at ensuring that we get enough resources to tackle alcohol and alcohol harm?

Neil Gray: I will make several points to Ms Mochan. First, reducing alcohol-related harm, as well as drug-related harm, is a clear priority for the Government, and it is one that we continue to invest in.

Secondly, on the resource that is going in, there is a cash increase to our alcohol and drug partnerships. I have already pointed to the additional £19 million of baseline funding, which is to give greater certainty to our alcohol and drug partnerships and will enable them to employ people in the projects that they are delivering for a longer period, rather than on a short-term basis. As a result, they will be able to deliver more sustainable services.

Thirdly, I point to our work on wider interventions. We have already increased the minimum alcohol unit price, which has had a demonstrable impact on reducing alcohol harm through fewer hospitalisations and deaths. We are also working with Public Health Scotland on alcohol advertising and on whether greater impact could be made, using an evidence-based approach, by using further restrictions. I expect Public Health Scotland to report back on that in the coming months. If further intervention is required from the Government, we will take those opportunities. There are a number of areas that we are investing in.

Lastly, the investment that we are making in our alcohol and drug partnerships includes £60 million a year for the drugs mission and reducing drug-related deaths, which takes us to £250 million across the lifetime of this Parliament. That supports the capacity for our alcohol and drug partnerships to ensure that they can meet the demands from people with alcohol dependency and from those with both an alcohol dependency and a drug dependency. I believe that that is making a demonstrable difference, and that we will continue to make progress. That is, in part, thanks to the investment that has been made; it is also due to the incredible work that has been delivered by the staff in the partnerships and those in the community and voluntary sector who are supplementing that.

Joe FitzPatrick: I have some questions about integration authority budgets and, in particular, transparency. When we look at the Scottish Government website, the latest data that we find relates to 2022-23. Given that it is a really important area for delivery, is there anything that the Government can do to increase transparency and provide more up-to-date financial information on IJBs?

Neil Gray: Sorry, but will you repeat that? I missed what you said.

Joe FitzPatrick: The financial information on integration joint boards that is on the website is not recent—it relates to 2022-23. Is there anything that the Government can do to improve transparency around the spending of IJBs?

Neil Gray: We can certainly look at that. I do not know whether Alan Gray has more information on it than I do.

Alan Gray: I am very keen, in the new year, to pick up further discussions with the chief finance officers and chief officers in IJBs to try to increase the transparency in order to help us to help them. If we look at the numbers, there is no doubt that IJBs are facing the same difficulties and challenges that health boards are facing. Clearly, they are independent—they are a step away from Government. However, we are keen to work closely with them to help us to understand better their financial issues and challenges, as well as where the money is going.

I hope that, over the coming year, you will start to see a greater level of reporting on IJB spend, which is significant and important. As we mentioned, IJBs will play an increasingly important role in addressing delayed discharges and reducing the pressures that we see in the hospital system. I see the IJB role as one that will increase in importance over the period.

I recognise your point. It is a challenge to me, too, in trying to understand their financial position, because it all heads to my desk eventually. I support your view on that. There is definitely some work that we could be doing to help everyone to understand more of what is going on with IJBs.

Joe FitzPatrick: On transparency, when we did our pre-budget scrutiny, there was some talk about the use of reserves—IJBs had maybe used a bit more of their reserves and they were going down. Audit Scotland had some comments on the use of reserves. I have looked back over the years to the pre-Covid era, and it looks like IJB reserves were around £150 million, but they are now well in excess of that in spite of the Covid moneys being returned.

My first question is for Alan Gray. What is your understanding of the reserves that are held by IJBs across the country? Secondly, cabinet secretary, what is your aspiration for that money? Should it be sitting there or should it be applied and used?

Alan Gray: Overall, the IJB reserve position has been decreasing in recent years. Some of that money is held for earmarked funds—it is committed for long-term plans. Part of it is in a reserve to meet a long-term financial commitment to implement either additional resource or an improvement. Some of it is earmarked for future years funding, which is absolutely right. It is good,

sensible planning for the future and for investing the right resources. Some of it is a general reserve, which would be available to support IJBs to meet in-year pressures, energy costs or any other pressures that they are facing. A small amount of the reserves is available for in-year support.

However, my understanding is that the number has been decreasing quite significantly and that, in 2025-26, fewer IJBs will have reserves—earmarked or otherwise—to use.

Neil Gray: Part of the discussion that we will be having with IJBs is about the deployment of the £100 million for improving the delayed discharges picture and ensuring that IJBs have the resource and certainty available to them to allow investment in care packages and care home support.

Mr FitzPatrick asked what my expectation would be. The reduction in the levels of reserves that Alan Gray has just narrated meets the fact that there is pressure across the public sector. I do not think that anyone would expect there to be high levels of reserves sitting there when there is fiscal pressure across public services. Those things need to be balanced. I acknowledge Audit Scotland's report in that respect, and the Auditor General's concern about ensuring that there is financial sustainability going forward.

We must continue to work with our partners in local government and health boards to ensure that there is funding sustainability for our IJBs so that they can continue to meet service demand and be sustainable over time. We need to ensure that that is a smooth process. Alan Gray talked about ensuring that the allocated reserves are there to allow investment over time and allow some of those multiyear projects to be delivered.

Joe FitzPatrick: You both mentioned delayed discharges as being an area where IJBs have a particular role. There is huge variation in performance across the country, and it is clearly not all just about budget. I am particularly pleased with the performance in NHS Tayside. It is not perfect, but the three local authorities are managing to work together to tackle delayed discharges in a way that some other areas have been unable to do. How can good practice in one set of IJBs be passed on to other parts of the country?

Neil Gray: Like Mr FitzPatrick, I am particularly pleased with where the IJBs in Tayside are on that. That has come about after a number of years of work in which the whole system has been geared towards responding to need. The whole system has bought into the way that the service is run and into ensuring that there is a good flow.

Mr FitzPatrick is right that there is not the same consistency in other parts of the country. I do not know whether I have done this in the committee, but I have certainly pointed out in the chamber the service difference in NHS Ayrshire and Arran, for instance. There is significant variation between the best performing IJB in Ayrshire and Arran and those that are struggling a bit more. My officials continue to work with the areas in which we need to see improvement.

10:45

This is not all about social care or local government; it is also about recognising that, from a healthcare perspective, we must get clinical pathways working well and efficiently. We should have in place discharge-without-delay processes so that we understand predicted dates of discharge and have discharges before noon and weekend discharges. All those things should be happening in the health service.

Where the best services are being delivered, there are clear and strong relationships between acute services and the community. I point to the phenomenal work that has been done in NHS Ayrshire and Arran on the frailty assessment units in the acute sites at Crosshouse hospital and University hospital Ayr. That has made a demonstrable difference for people with frailty who arrive in accident and emergency departments. There are better lines of communication between our unscheduled care services and those in the community, so there are better connections and people are able to be discharged before being admitted into the wider hospital. The best way of reducing delayed discharge is by avoiding admissions in the first place. The work that we are doing through the investments in this financial year is about ensuring that we have those strong and sustainable frailty assessment units across Scotland.

The clear lesson from NHS Tayside is that good, strong integration between health and social care services and community services is paramount. My team and the Convention of Scottish Local Authorities are working very closely to achieve just that.

Brian Whittle: When I spoke to the health board and the local council in Ayrshire recently, they both said that we need to stop talking about delayed discharge and start talking about flow through the hospital. In Scotland, generally speaking, people spend too much time in hospital, and we need to deal with that. Surely that is a job for AI, which can be used to predict when people will come in the front end and out the back end. Is it not time that we looked at that, rather than just keeping on talking about delayed discharge?

Neil Gray: I do not think that it is an either/or. We have to address hospital capacity. Hospital

occupancy rates across Scotland are far too high and there are people in hospital who have been there for too long. The lengths of stays in hospital are too long, and one of the drivers of that is delayed discharge. There are people who stay in hospital for far too long, and we need to get them out into the community.

Artificial intelligence is an option if the technology is available for us in that regard. However, as I said to Mr FitzPatrick, proper collaboration between our acute sites, the community and our health and social care partnerships is critical in ensuring that we recognise and address the needs of individual patients. I saw evidence of some of that work in East Lothian when I sat in on a morning huddle in which we looked at what work was being done to get each patient in an acute setting back into the community.

As I said, some of the pressure in our hospitals, with the performance of our accident and emergency departments sitting at too low a level, is driven by hospital occupancy rates being too high, the lengths of people's stays in hospital being too long and, as Mr Whittle set out, people not moving back into the community—into their own homes or other facilities—quickly enough. The £100 million that we have set out is about addressing those issues and allowing primary care to hold more patients in the community for longer.

We need to invest in all those areas, because we need to take a whole-system approach in order for things to work. We need to look at all possible avenues and opportunities, including the use of technology and direct resources.

Alan Gray: It is clear that getting the patient to the right location in the hospital is vital. We have focused on ensuring that, when a patient is admitted at the front door, they are admitted to the specialty that can best look after them. In the hospital at home service, it is about having the right information and the right decision makers in the room to support a decision on whether to discharge the person or hold them, or whether to keep them at home and in the community.

Brian Whittle is right that it is about having the data, but having the key decision makers is just as important. If they are there, they can make the right decision for the patient with that good information and data.

Neil Gray: Alan Gray is right that, where hospital occupancy is sitting as high as it is at some acute sites, our clinicians' ability to meet the patients' needs and the efficiency of the flow of the hospital are reduced.

Hospital at home is another incredible example of how we can meet patient needs and expectations. Patients are treated literally in their own homes and are kept at home for longer. Our investment in the budget will take us on a pathway to reach 2,000 hospital-at-home beds by the end of 2026, which would make hospital at home the largest hospital in Scotland. That is right for patients and for the health service, and that is why it has been an important innovation in the NHS over the past years.

Sandesh Gulhane: Cabinet secretary, £21 billion is a big budget, and you have described it as a budget for delivery. However, funding does not replace leadership, and accountability is vital in that regard. I hope that you agree that you are ultimately responsible, but do health boards and senior managers not also have some accountability?

Neil Gray: Yes—we all do. All those who are at leadership and decision-making levels have responsibility and accountability for delivering health and social care services. Sandesh Gulhane is right that, ultimately, I am the health and social care secretary and the buck stops with me. That is why I am determined to show the leadership that I can to deliver against the priority areas with the budget—reducing waiting times, increasing access to primary care services and reducing delayed discharge. If we achieve against all those areas, we will improve the system for our patients and create a more sustainable service, which is what we all want.

Sandesh Gulhane: On reducing waiting times, NHS Tayside appears to be suspending orthopaedic surgery to alleviate pressure on hospitals over the winter period, which shows winter pressure in action. Over the weekend, you said that winter pressure is not as bad in reality. How does that decision align with your stated outcome of reducing long waiting times?

Neil Gray: I do not remember saying that winter pressure is not as bad in reality. I am not sure where Mr Gulhane's reference comes from.

There is pressure at all times of the year, and our health boards need to be able to have a surge capacity response to meet the demands on them. For example, at the peak of the last wave of Covid-19 in the summer, 600 beds in Scotland were taken up with Covid patients, which is equivalent to the capacity of Wishaw general hospital. We have pressures in winter, but that example illustrates that pressures and surges can happen throughout the year. That is why it is important that we give our boards the flexibility to be able to respond to those in ways that are right in their areas.

On what Mr Gulhane referenced in relation to NHS Tayside, the budget is about creating greater capacity in the health service to meet scheduled care demand and planned care and to reduce

waiting times. We are working right now at increasing that capacity and ensuring that we can have a better run rate so that more patients are treated. We will eat into and erode the longest waits so that patients can get the treatment that they need.

Sandesh Gulhane: On those longest waits, 11,000 people are waiting over two years in Scotland. On the weekend, you said that an expansion in scheduled care capacity is needed to eradicate long wait lists by 2026. In July 2022, your predecessor, Humza Yousaf, promised to eradicate long waiting times by now. Who was accountable for that failure, and who will be accountable for your promise?

Neil Gray: I will be accountable for the progress that the budget is able to make. I am confident that we will be able to reduce waiting times. The investment that we will make, which I hope colleagues round the table will recognise is needed and which I therefore hope that they will vote for, will deliver £100 million of greater capacity in scheduled care. That will allow a capacity increase, which I hope will be sustained, to address our waiting times.

We estimate that that funding will provide 150,000 patients with treatment, whether that is surgery or diagnostic scopes and scans. That will enable us to reduce waiting times by March 2026, which is a critical commitment in the budget and one for which I will be held to account. We are working with our boards—particularly those that have regional or national centres such as the Golden Jubilee hospital and our national treatment centres—to ensure that they are able to maximise their capacity and run rates so that we can get through those patients.

I recognise that, if anybody waits too long for treatment and care, their wider health and mental health can deteriorate. Some of those patients then pick up other issues and conditions, which we want to avoid. That goes back to the point about prevention. We can deliver various levels of prevention and, by reducing waiting times, we can reduce the impact that some of those conditions can have on a person's wider health.

Reducing waiting times is a fundamental priority and I have set it out in the budget. The £30 million that was invested this year has made a demonstrable difference and started to reduce some of the longest waits across Scotland. It has provided a starting point of capacity that we need to build on, and that is happening as we build towards the £100 million coming into place in April.

Sandesh Gulhane: Cabinet secretary, who is responsible? Have you held health boards accountable for not delivering Humza Yousaf's promise in 2022? Who has been held accountable for that failure?

Neil Gray: That is a fair challenge. I am answering questions about where we are now. We will invest in the health service to reduce the longest waits. We have embarked on that, with the starting point being £30 million this year, and £100 million will come into the budget next year. That is to ensure that we reduce the longest waits, because I recognise that we are not where we want to be. I accept the fact that we have not made the progress that we want to make.

That being said, I have confidence in the plan that is before us to build on the £30 million that came through last year and the £100 million that is coming from April. We are investing capital and resource to make sure that we increase capacity and are directing capacity towards the national treatment centres and regional hubs to ensure that we maximise the efficiency and productivity of the system. I am confident that we will meet the commitment that we set out in the budget.

Of course, that funding can arrive only if colleagues round the table vote for it and a budget is passed. Because the Scottish Government does not command a majority in Parliament, if we want waiting times to improve, we need to vote for it. That will be an important consideration for all of us in the coming months.

Sandesh Gulhane: We know that there is a marked difference in the quality of dental care for people in the most deprived areas versus those in the least deprived, especially our children. How will you monitor the contribution that the additional funding that is going into general dental services makes to continuing improvements to address oral health inequalities?

Neil Gray: Sandesh Gulhane is right that there is an oral health inequality, but it has reduced substantially. I hope that Alan Gray has access to the figures. Child oral health inequality has reduced substantially. We have seen a reduction in the number of children who arrive at dental services with cavities, so the childsmile programme has clearly made an impact and reduced inequalities.

The reason why we have invested in general dental services and reform of the funding for NHS dentistry is to ensure that our dentists find carrying out NHS work more attractive. That is also why, in the budget, we are investing in increasing the number of dental training places so that we can increase the number of dentists coming into the system. We are increasing the number of Scotland-domiciled dental places by 10 because we recognise that it is an incredibly competitive environment for potential students to go into and

we want to ensure that we maximise the number of dentists who come into the health service.

I am happy to provide greater detail on the reduction of childhood dental health inequality in the follow-up correspondence. The information gives a good summary of the progress that has been made and the impact that childsmile has made. I think that Mr Gulhane will welcome that.

The Convener: I thank the cabinet secretary for attending. I also thank Alan Gray.

I will suspend the meeting briefly to allow a change of witnesses.

11:01

Meeting suspended.

11:11

On resuming—

Tobacco and Vapes Bill

The Convener: Agenda item 3 is an evidence session with the Minister for Public Health and Women's Health and her supporting officials on the Tobacco and Vapes Bill legislative consent memorandum, LCM-S6-51, which was lodged in the Scottish Parliament by the Cabinet Secretary for Health and Social Care on 21 November.

The legislative consent process set out in chapter 9B of the standing orders requires the Scottish Government to notify the Parliament, by means of a legislative consent memorandum, whenever a UK Parliament bill includes provision on devolved matters. Each LCM is referred to a lead committee to scrutinise and report on, before the Parliament decides whether to give its consent to the UK Parliament legislating in the manner proposed.

The Tobacco and Vapes Bill was introduced in the House of Commons on 5 November 2024. The purpose of the bill is

"to make provision about the supply of tobacco, vapes and other products, including provision prohibiting the sale of tobacco to people born on or after 1 January 2009"

and to make provision

"about the licensing of retail sales and the registration of retailers; to enable product and information requirements to be imposed in connection with tobacco, vapes and other products; to control the advertising and promotion of tobacco, vapes and other products; and to make provision about smoke-free places, vape-free places and heated tobacco-free places."

I welcome to the committee Jenni Minto MSP, Minister for Public Health and Women's Health; Professor Linda Bauld OBE, chief social policy adviser; Fiona Dill, teams leader for the tobacco, gambling, diet and healthy weight directorate; and Ruth Foulis, lawyer with the legal services directorate.

I invite the minister to make a brief opening statement.

The Minister for Public Health and Women's Health (Jenni Minto): I am delighted to be here to provide evidence on the Tobacco and Vapes Bill LCM, which was lodged in our Parliament on 21 November.

I am sure that, like me, committee members were disappointed when the previous version of the bill fell at the dissolution of the UK Parliament. However, I tend to think that things happen for a reason, and the reason in this case was the opportunity to create a stronger bill.

I remain committed to a tobacco-free Scotland by 2034, which, at its core, has the aim of Scotland being a nation where people live longer and healthier lives. This UK-wide Tobacco and Vapes Bill will help us to achieve that.

Although smoking rates have reduced in recent years, people are still taking up smoking. Cancer Research UK estimates that around 350 people start smoking tobacco each day, with the vast majority of those—nine out 10—starting before the age of 21, and with people living in our most deprived areas being most likely to start.

The bill is about stopping that start—it is about creating a generational change, meaning that those born after 1 January 2009 will never legally be able to buy tobacco. The bill will gradually increase the age of sale for tobacco products and provide powers to legislate on vape flavours, displays and packaging, as well as introducing an advertising ban for vapes and nicotine products.

This landmark legislation will ban vapes and nicotine products from being deliberately promoted and advertised to children, to stop the next generation becoming hooked on nicotine. The bill will provide powers to extend the indoor smoking ban to certain outdoor settings, subject to full consultation. If passed, with the consent of the Scottish Parliament, the bill will benefit public health in Scotland and help to save lives.

11:15

As I have indicated, the bill also helps to take forward actions in our tobacco and vaping framework. We have worked closely and collaboratively with the UK Government and with other devolved Governments on the bill, and have absolutely ensured that the bill works for Scotland and will deliver impactful change.

Colleagues around the table will remember back to the time before the 2006 indoor smoking ban or to a time when tobacco was advertised and openly displayed in shops. Before legislative changes came into effect, it was hard to think of life without a smoking area in a restaurant or without a racing car covered in red and white or black and gold. We could only dream of such things not existing. It is now hard to think of a world where that would be acceptable.

This bill, like the legislation before it, creates that break with the status quo and provides the opportunity to do something impactful for the next generation, with tobacco, specifically, becoming something that is relegated to history. We have the opportunity for future generations in Scotland to learn about tobacco from books and not to experience its devastating consequences. I therefore recommend that the Scottish Parliament consents to the legislative consent memorandum.

The Convener: Thank you very much, minister. The committee has a number of questions about the LCM. On a point of clarification, you referred in your statement to nicotine products. Can I check that the bill would not cover smoking cessation products such as lozenges, chewing gum and patches?

Jenni Minto: That is correct. Clause 60 of the bill sets out that the meaning of "nicotine product" includes

"nicotine, or any substance containing nicotine, which is intended to be delivered into the human body"

but we still need ways of providing cessation products for people who wish to cease smoking.

The Convener: Thank you very much for that clarification.

Gillian Mackay: Good morning, minister. How would you respond to criticisms that existing restrictions on vaping and tobacco are not being adequately enforced?

Jenni Minto: The Scottish Government works closely with local authorities and with the Society of Chief Officers of Trading Standards in Scotland on that. We invest about £3 million into that work and also £50,000 to ensure that we have that relationship.

One of the important things about the bill is the fact that it is across the four nations. The UK Government has invested £100 million over five years to support HM Revenue and Customs and border control to ensure that we can reduce the amount of illicit products coming in.

Enforcement is important and that is the work that we continue to do and have great conversations about with local authorities. We also have the register of tobacco and nicotine vapour product retailers in Scotland, which helps us. It includes every retailer that sells cigarettes and other nicotine products, so we can get that information from them as well.

Gillian Mackay: The register is obviously very different to the way that we handle alcohol licensing, for example. As a result of some of the things that are happening through the bill, does the Scottish Government have any plans to put additional restrictions in the register, to bring it in line with how we regulate other health-harming products, such as alcohol?

Jenni Minto: We are working just now—because it is part of our tobacco and vaping framework, which was launched last year—to ensure that we have a register that is fit for purpose, not only for those of us who are tracking the retail elements of nicotine products but for retailers, to ensure that they get the right information. The investment is going into the

register just now. Of the four nations, we are the only one that has a register for tobacco and vapes, and that is very positive.

Gillian Mackay: There are various provisions in the bill. Some are about the sale of vapes, but some are about smoke-free environments. We are supposed to have smoke-free environments outside hospitals, for example, but from my inbox as well as my experience, I know that that is not necessarily what is happening outside our hospitals at the moment. What comfort or assurance can the minister give people that the powers that are coming to the Scottish Government will be enforced and that we will see smoke-free environments happen? At the moment, for the most part, it is not happening outside hospitals, where it should be.

Jenni Minto: I thank Gillian Mackay for that question and empathise with her experiences. I see the same thing outside hospitals. I am pleased that we are working with Action on Smoking and Health Scotland, which is doing a report on the impact of smoke-free zones outside hospitals, and that work is also being extended to other spaces. However, I have to be clear that we will not be introducing any additional spaces without proper and robust consultation and engagement with all stakeholders and the general public.

Sandesh Gulhane: I declare an interest, as I am a general practitioner in the national health service.

Could you give me some examples of herbal products that are going to be banned?

Jenni Minto: As I understand it, not being a smoker and not being a user of herbal products, there are herbal products that are made into cigarettes, and nicotine pouches are also used.

Sandesh Gulhane: Nicotine pouches are different to herbal products. I will have questions about the pouches, but first, are the herbal products that are to be banned those that contain nicotine?

Jenni Minto: Again, my understanding is that herbal products do not necessarily contain nicotine, but they contain substances that can have a carcinogenic impact, as well as tar. That is why they are included in the legislation.

Professor Linda Bauld (Scottish Government): We are mostly worried about combustion. If someone is smoking even a herbal product, they are going to create combustion and particulate matter that, as we know, has toxicants and carcinogens that are harmful, particularly to the lungs. The primary focus is therefore herbal smoking products. As you say, nicotine pouches are something different. I hope that is helpful.

Sandesh Gulhane: The biggest herbal product is cannabis. Is that included in the bill?

Fiona Dill (Scottish Government): The bill does not include cannabis in herbal smoking products.

Sandesh Gulhane: Professor Bauld, you said that the problem is combustion, which creates particulate matter, which then harms the lungs. That is exactly what happens when people smoke cannabis.

Professor Bauld: My understanding is that we have separate legislation for drugs, but I am not an expert on that so we might wish to hand it over to others.

The concern about herbal smoking products, as distinct from cannabis, is that we did not include herbal smoking products—not cannabis, and not herbal smoking products that contain cannabinoids—in our previous tobacco control legislation, so there was a loophole. People are smoking things that are not cannabis but they might be mixing tobacco with other herbal products and so on that are not included in tobacco control legislation. That loophole means that people are exposed to harm. We are not treating that category of products in the same way as we are treating some other products. That is the intention behind including those herbal products in the bill. There might be separate arguments about cannabis, but that is separate from this legislation.

Sandesh Gulhane: I will move on to talk about pouches. You mentioned snus, which is very popular in Scandinavia; it seems that almost everyone in Scandinavia is taking the product. What is the evidence for banning it?

Jenni Minto: Snus has been banned since 1992.

Sandesh Gulhane: Why is it specifically mentioned in the LCM?

Jenni Minto: It is included in the legislation so that it is all in the same legislation and so that there is consistency.

Sandesh Gulhane: What about visitors to the UK who bring in snus?

Jenni Minto: That is a very good question. I will hand over to Ruth Foulis.

Ruth Foulis (Scottish Government): Currently, the provisions will cover possession with intent to supply. If someone is in possession for personal use, that would not be covered.

Sandesh Gulhane: What about a UK citizen who has it for personal use?

Ruth Foulis: If a UK citizen bought snus outside of the UK, in a country where it was legal to do so, and brought it into the UK for personal use, that would not be covered by the prohibition provisions that are already in the Tobacco and Related Products Regulations 2016. Those provisions are being removed from the regulations and brought into the Tobacco and Primary Medical Services (Scotland) Act 2010. The prohibition that currently exists will remain the same.

Sandesh Gulhane: Minister, you said that snus has been banned since 1992. We still smoke and we have a drug consumption facility coming in where people will consume drugs and be able to buy them. What was the evidence behind banning snus?

Jenni Minto: I cannot respond with regard to the evidence for banning snus, but I remember very clearly back in the 1990s when it was a problem, and there were a lot of news stories about snus. I remember the impact that it had—mouth cancer, for example. We are looking at tobacco, vapes and other nicotine products. As I said in my introduction, this is positive legislation that looks to stop people before they start and ensure that young people who are born after 1 January 2009 do not have the opportunity to use those nicotine products. Doing that is incredibly important. I do not know whether Ruth Foulis has anything to add in answer to Dr Gulhane's questions on snus.

Ruth Foulis: As far as I understand it, the prohibition was decided at European Union level when we were EU members. We implemented that prohibition and it remains in place. As far as I am aware, the evidence at the EU level was that, as it was a novel product, which beyond certain Scandinavian countries had not yet developed a market and was viewed as a risk, they would treat it slightly differently from other tobacco products that already had a market in the remaining non-Scandinavian EU states. They thought that the best step forward was to introduce the prohibition. I do not think that we have any evidence to suggest that that should be rolled back. I was a small child in 1992, so I cannot speak about any lived experience of those discussions. However, from reviewing what we are doing this time around, that appeared to be the evidence basis.

Sandesh Gulhane: Lucky you.

Professor Bauld: Snus is a low-nitrosamine tobacco product. The evidence has evolved. Ruth is absolutely right that the decision was made on the basis of EU legislation about not allowing into the EU another novel product that was not risk-free and which would complicate the tobacco control measures that we had at the time. There has never been an appetite to lift that ban.

It is the case that low-nitrosamine oral tobacco products are less risky than other oral tobacco products that we know are used by communities in the UK. However, as Ruth said, the decision was taken not to allow that category of products to be sold in the EU and it still stands.

11:30

Brian Whittle: Good morning, minister and guests. I want to go back to the question of how we enforce the legislation. When I pick my daughter up from school, I am always shocked by the number of kids who are openly vaping. If you talk to the on-site police officer, he will tell you about the amount of product that he takes off kids daily—bags full of the stuff. If it were down to me, I would take a much harsher approach and ensure that the products were used only for smoking cessation.

Given, in particular, the disparity between Scottish index of multiple deprivation 1 and SIMD 5 areas when it comes to smoking, how will we ensure that the legislation is enforced under the new LCM? After all, it is not being enforced just now.

Jenni Minto: I thank Brian Whittle for his question, and I recognise the picture that he painted at the start of it. When I visited a school in my constituency, I was pretty shocked to see the handful of disposable vapes that a teacher produced. Therefore, I absolutely understand where Mr Whittle is coming from.

I agree that we need to improve enforcement, which is why we, as a Government, have a very good and close working relationship with the local authorities. In answer to Gillian Mackay's question I indicated that we are investing £3 million directly in local authorities to support enforcement, and we also have an important working relationship with the Society of Chief Officers of Trading Standards in Scotland. Moreover, we already have fixed penalty notices in place. The important message that will be sent with the passing of this bill and the additional UK-wide regulations on displaying vapes will, I hope, help with enforcement, too.

Brian Whittle: Just as a follow-up, what we are discussing and describing are penalties for breaking the law, but the flipside to that is this: how do we educate our kids in such a way that they decide not to go down that route in the first place? Is there any complementary way in which this legislation will be backed up?

Jenni Minto: I agree that education is incredibly important. In four or five local authorities, we have a pilot called project youth, which is also known as the Icelandic model, and it works directly with schools, the parents and the wider community on issues such as health, including the negativities

around smoking and the impact that it can have on children's lives as they grow up.

Moreover, we have, through curriculum for excellence, a lot of teaching on health improvements and on things that can support a person's health and other things that can have negative health impacts. I am very much old enough to remember the snus that we were talking about earlier, but I also remember how, when I was in primary school and doing a project using advertisements, all the ads were for cigarettes.

That situation has completely changed now. I think that we have made a really important step forward in schools, and it is something that we need to continue. When the Scottish Children's Parliament was at Cabinet a couple of weeks ago, one of the things that its members had a conversation directly with the cabinet secretary on was reducing the use of vapes, because they felt so strongly and passionately about the issue.

Brian Whittle: Could you, through the LCM, create further restrictions on access to the likes of vapes and who can retail them?

Jenni Minto: The retail side is handled through our register, which I talked about earlier and which includes shops that stock vapes. With regard to spaces and where people can vape, as I said, we will consult on that once the bill has passed. With regard to displays and flavours, there is UK-wide legislation on that, and we will work with the UK Government on its implementation.

Joe FitzPatrick: I feel that I should first declare that I, too, am old enough to remember when the John Major Government banned snus. There was quite a bit of television coverage at the time about the risks of that novel product potentially coming to the UK.

I want to ask about retail and sales. We have had comments from the retail industry, particularly from the Scottish Grocers Federation, about the practicality of complying with the regulations. The federation raised a concern about the age at which adult staff will be able to sell tobacco products, which is increasingly getting older and older. Might that actually provide a public health benefit? As it becomes more difficult for retailers to routinely supply tobacco products before they are completely gone, many will decide not to sell those products and we will find that tobacco is no longer universally available. Would that reduced availability make it easier for people to give up smoking, because they would not be surrounded by tobacco products in the way that they are now?

Jenni Minto: As I said in my opening remarks, between 80 and 90 per cent of people who start smoking do so before they are 21. From my perspective, it is important to recognise that and to recognise the importance of prevention before people start. You raise really important points about the recognition of products. If you go into anywhere that sells tobacco, the grey blinds are pulled down and you cannot see the products. With vapes, there is basically a rainbow of colours and flavours that are very attractive to young people. Evidence would show that flavours such as candy floss, gummy bear and watermelon are there to attract children. That is why it is so important to have UK-wide legislation, because it gives consistency across the four nations for consumers and for retailers.

Joe FitzPatrick: Thank you.

Sandesh Gulhane: I read recently that vapes do not seem to be one of the better ways of stopping smoking. Do you agree with that?

Jenni Minto: There are a number of ways in which people can cease smoking. I am pleased that figures out just today show an increase in the number of people who are using cessation services in the NHS in Scotland. I think that the figure is now over 30,000, which is back to pre-pandemic levels, which is really positive.

There are a variety of approaches and treatments that people can use to stop smoking. Linda Bauld is the expert on that, so I will bring her in.

Professor Bauld: Dr Gulhane, did you say that you read that vaping is not effective for smoking cessation?

Sandesh Gulhane: Yes.

Professor Bauld: That is not the case. As the minister said, there are lots of different ways to quit. The most common way that people try to quit is to use nothing, and the success rates there are very low. The quit your way services increase the chance of success and cessation by three to four times, through a combination of counselling and stop-smoking medication.

The evidence on vapes has been growing over the years. You will be familiar with Cochrane reviews, which are the gold standard for systematic reviews. The first Cochrane review on vaping was in 2014, and it has been updated regularly since then, so we have a decade of evidence. In the first review, there was low-certainty evidence of success for smoking cessation—it is now high-certainty evidence. Over 22 studies, including tens of thousands of people, the odds ratio for e-cigarettes—which I have here—is 2.37 for six months' cessation. We can compare that with the ratio for varenicline, our most successful medication, which is about 2.33. E-cigarettes are a highly effective way to quit, and they are very popular, but the best way to quit is through a combination of behaviour plus medication or vaping.

Thinking about the research and the science, the important thing, in my view, is to strike a balance between recognising that we have to find ways to make these products appropriately available to adult smokers who want to quit, while in this legislation—as the minister said—absolutely preventing smoking uptake and preventing the harms of vaping among young people and non-smokers.

Sandesh Gulhane: Thank you for the clarification; the thing that I read was clearly not correct. We have a very high smoking rate in Scotland in comparison with the rest of the UK. Nonetheless, given that it is still a small proportion of people in Scotland who smoke, is there an argument to be made that we could have a generation that is smoking and vaping free?

Jenni Minto: I am sorry, Dr Gulhane—I lost the train of that question.

Sandesh Gulhane: Could we put vaping and smoking together and ban sales to a generation to make our future smoking and vaping free?

Jenni Minto: The focus of our work over the next 10 years—or nine years, because it is a year since it was launched—is on the tobacco and vaping framework, which looks towards a tobacco-free Scotland in 2034. The UK legislation came in as we were developing our framework, and the Scottish Government has been very pleased to support it because we believe that it moves not only Scotland, but the entire UK, into the ballpark of aiming to be tobacco and vape free in 2034.

Sandesh Gulhane: One of the difficulties that the legislation will face will not arise right now, because when it is introduced, it will be obvious what a child is in comparison with an adult. However, as the years roll on and people get older, the difficulty with the legislation will be people's age, as they will look older. Do you foresee any difficulties, as people age with the legislation, that the identification of people to enable them to access tobacco and vapes might not be as good as we would hope?

Jenni Minto: There is currently a need for people to confirm their age when they are buying products if the retailer is at all concerned, so that is something that is accepted. The point—which I have made before—is that between 80 and 90 per cent of people who start smoking do so when they are under 20, so by the time the legislation moves through, if it is successful, it is clear that there will be fewer people starting to smoke.

I go back to the point that the legislation is here to help us stop the start, and that is a strong message that everyone should recognise.

Sandesh Gulhane: I have a final question with regard to what happens with people who have cigarettes when they are under the age that they should be, regardless of whether, in time, that age changes. Obviously you are repealing the law for under-18s, because that will not make any sense going forward, but I have not seen what is replacing that. What would be the punishment for people buying cigarettes for people who are under the age as set out in the LCM? What is the punishment for people who have possession of, and are using, these products outside of when they should be?

11:45

Jenni Minto: That provision of the legislation that will be repealed is specific to Scotland. We had consulted and taken advice from other organisations, including ASH Scotland, which felt that it was not appropriate to criminalise someone's addiction to nicotine or tobacco. That is why that aspect of the legislation will be repealed. As I say, we are the only nation of the four UK nations to have that provision. There is absolutely no change to the legislation in relation to proxy buying for underage people or in relation to retailers selling to underage people. The legislation will change only to remove criminalisation of under 18s.

Sandesh Gulhane: Thank you.

Emma Harper: Good morning, minister. I am interested in the vaping issue, as I am co-convener of the cross-party group on lung health, and ASH Scotland has come and presented to us. I am thinking about how retailers seem to be everywhere now—taxi drivers are selling vapes and online food companies will sell vapes as part of your food delivery. How will retailers be educated on or supported in the change in the law?

Parents need to realise the damage that nicotine does to their children. We hear about kids who are so anxious that they cannot sleep, and when they try to withdraw from vaping, they have withdrawal issues. There are total health impacts for young people who vape, so I welcome this legislation, but how do we make sure that retailers are aware of it, and how do we curtail the number of businesses that are selling vapes?

Jenni Minto: There are lot of questions wound up in that. I go back to the development that we are currently doing on the register of tobacco and vape products. That involves changing a platform, which will become a much more useful tool for putting out information to retailers and for getting information back from retailers. The register is really important.

As with any change in regulation, if the bill goes through, we will need to work closely with retailers and have those conversations to ensure that they

know about the legislation. That is absolutely key to making this work.

With regard to ensuring that parents are aware of the impacts of tobacco and vaping, I have already highlighted project youth, also known as the Icelandic model, which has had amazing results in improving the health of younger people. In Scotland, at the beginning of this year, we had the take hold campaign, which was specifically aimed at parents and carers to ensure that they understand the impact of vaping on young people's health. I was really pleased that women's football used the advert at their cup final at Tynecastle, which pushed it out to an audience that needs to be aware of the impacts.

I also refer to the answers that I gave to Mr FitzPatrick and Mr Whittle—education through curriculum for excellence ensures that children understand the impacts of things on their health.

Emma Harper: Thanks.

The Convener: I thank the minister and her officials for giving evidence today. This is the final meeting of the Health, Social Care and Sport Committee in 2024. At our next official meeting, on 14 January, we will resume our stage 1 scrutiny of the Assisted Dying for Terminally Ill Adults (Scotland) Bill.

On behalf of the committee, I take the opportunity to thank everyone who has contributed to our work this year and to wish everyone a happy and restful festive period. That concludes the public part of our meeting.

11:49

Meeting continued in private until 12:13.

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EH99 1SP

Email: official.report@parliament.scot
Telephone: 0131 348 5447

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