OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 25 February 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

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HEALTH AND SPORT COMMITTEE
5th Meeting 2020, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Joe FitzPatrick (Minister for Public Health, Sport and Wellbeing)
Jeane Freeman (Cabinet Secretary for Health and Sport)
Richard McCallum (Scottish Government)
Fern Morris (Scottish Government)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 25 February 2020

[The Convener opened the meeting at 10:01]

Budget Scrutiny 2020-21

The Convener (Lewis Macdonald): Good morning, and welcome to the fifth meeting in 2020 of the Health and Sport Committee. We have received apologies from David Stewart. I ask everyone in the room to please ensure that their mobiles are off or in silent mode. Please do not use mobile devices for photography or for recording proceedings.

The first item on our agenda is an evidence session on the budget for 2020-21. Our approach to scrutiny of the budget has reflected the approach that was recommended by the budget process review group, which involves addressing budget implications throughout the year and bringing the information together to inform a pre-budget report for consideration by the Government. Our pre-budget report was issued on 3 October, and it set out some recurring themes and issues that we identified in relation to the Scottish Government's plans. Obviously, the timing this year was different from usual, for understandable reasons, but we received a detailed response from the Cabinet Secretary for Health and Sport on 6 February.

I am delighted to welcome to the committee the Cabinet Secretary for Health and Sport, Jeane Freeman, who is accompanied by Richard McCallum, interim director of health finance and governance at the Scottish Government.

I believe that the cabinet secretary wants to make some initial remarks.

The Cabinet Secretary for Health and Sport (Jeane Freeman): Thank you very much, convener. Good morning to you and to colleagues. As always, I welcome the opportunity to give evidence on our budget proposals for health and care services.

The 2020-21 budget puts in place the funding that we need for continued improvements across the whole system—in patient care and in the delivery of better health and value for the people of Scotland. To deliver those improvements, the draft budget spending on health and care services will exceed £15 billion for the first time.

The funding settlement sees every penny of additional health resource and capital consequentials passed on in full. In addition, the Scottish Government has allocated more than £100 million over and above consequentials specifically to support the national health service in Scotland and to mitigate the impact of funding shortfalls from Westminster.

Through the budget, we will continue to build on our record level of front-line health spending in Scotland, which currently stands at £136 per person—that is 6.3 per cent higher than in England. To support the measures that are set out in the health and social care medium-term financial framework, funding for front-line NHS boards will increase by £454 million—that is 4.2 per cent. That underlines our commitment to front-line services and delivers funding greater than the requirement recognised in the financial framework. We have also ensured that all NHS boards are within 0.8 per cent of their target funding shares, which is the closest that all boards have been to parity since the national resource allocation formula was established.

To support the measures in our financial framework, the Scottish Government will increase its package of investment in social care and integration. The investment will increase by an extra £100 million, taking the total investment package to £811 million from the health portfolio, which underlines our commitment to supporting older people and those with long-term conditions and recognises the vital role that is played by unpaid carers. Through those measures, we have ensured that we remain on track to deliver more than half of front-line spending in community health services by the end of this session of Parliament. We have key investment areas in innovation: hospital at home, attend anywhere, digital, and thrombectomy.

Our budget will deliver increased investment in waiting times of £30 million, which builds on additional investment of £146 million over the previous two financial years, which continues our efforts to improve access to hospital-based services through our waiting times improvement plan. We will make an additional £12.7 million available to tackle the harm that is associated with the use of illicit drugs and alcohol, which is a 59 per cent increase in direct funding from the Scottish Government that comes on top of spending baselined to NHS boards to address those issues.

We are clear, however, that we need to do more to support reform and ensure the continued delivery of sustainable person-centred services. Our investment of more than £9.4 billion in health and social care partnerships is key to achieving that reform, as is our direct investment to improve primary care and mental health.

The investment in primary care supports the implementation of the new general practitioner contract, making sure that general practice continues to be an attractive career and safeguarding service provision now and for the future. We will progress work to build multidisciplinary teams in primary care, making sure that patients can see the right person at the right time, thereby improving access and outcomes.

The budget will also deliver additional funding for mental health services, underlining our programme for government commitments to support positive mental health and to respond effectively when mental ill health is experienced.

Our 2020-21 funding will widen our approach on access to children and young people's mental health services and progress our commitment to provide 800 additional mental health professionals by 2021-22. We will also implement new measures to improve on our approach to mental health, such as the adult mental health improvement collaborative and the distress brief intervention programme.

The budget includes funding support to increase bursary provision for student nurses and midwives and to continue increasing the number of training places for medical, nursing and other areas of the workforce.

We know that being active is one of the best things that we can do for our physical and mental health. The budget will continue to support people in Scotland in that area by investing in places and spaces to provide opportunities for all to participate in sport and physical activity. We will continue to work with sportscotland to protect sport investment, and we will continue to underwrite potential shortfalls in lottery funding, as we have done in previous years.

In 2020-21, capital investment will increase by more than £90 million to £428 million. Investment in our infrastructure will be used to support delivery of the Baird family hospital and the Aberdeen and north centre for haematology, oncology and radiotherapy—ANCHOR—centre. The investment will also be used to increase elective capacity across the country through our elective centres.

We will provide additional resource funding to continue implementation of the Scottish trauma network, supporting the development of two centres in Edinburgh and Glasgow, which will add to those that are already open in Dundee and Aberdeen.

The budget for 2020-21 takes investment in health and social care services to more than £15 billion for the first time. We will protect front-line services and continue to shift the balance of care towards community health services. We will continue our twin approach of investment and reform in primary and social care, mental health and waiting times, and we will maintain a strong focus on our NHS values, delivering care that is safe, effective, person centred and timely.

I commend the budget to the committee.

The Convener: Thank you, cabinet secretary. I will start with the point that you made at the end of your opening statement about shifting the balance of care to community health services. The committee has supported your direction of travel on that, but we have asked you this question previously and I will ask it again this morning. The most recent number we had for end-of-year operational outcome was 49.7 per cent, although the target is over half. Do you expect to pass that mark in the upcoming budget? If you do, is it a sufficiently ambitious target, or do you believe that you can go beyond 50 per cent?

Jeane Freeman: Our target is 50 per cent in the current parliamentary session. From memory, I think that the target in the draft budget is 49.7 per cent, and that 0.1 per cent increase represents an additional £200 million. I expect that, by the time we get to the next budget, we will have reached the 50 per cent target.

Although the 50 per cent figure is important, how the money is spent is equally important, as is ensuring that we have the right levers to ensure that the significant additional resource secures a shift in the balance of care. We have discussed previously with the committee how the money is spent and how we can be sure that it achieves the outcomes that we are seeking. That has been the subject of continuous discussion between me and our Convention of Scottish Local Authorities colleagues—particularly my counterpart, Councillor Currie.

We are now moving towards an approach that includes shared accountability, because shifting the balance of care requires an effective partnership with our local authorities through the investment that is made jointly in those areas. I hope that the discussions that are still going on will produce some additional positive steps whereby the commitment to shared accountability for shifting the balance of care can be more effectively realised and more clearly reported to the committee and other colleagues—and, more important, to the wider Scottish public.

The Convener: An important part of meeting that 50 per cent target is reaching 11 per cent spend in primary care, again by the end of the current parliamentary session. Will you comment on progress towards that target in this year's budget?

Jeane Freeman: It remains on track. The proposals in this year's budget are for 10 per cent of the NHS budget to be spent in that area—additional spend on primary care will take the figure to 10 per cent of the overall spend.

The Convener: In your earlier answer, you said that you would look to more effectively present or report on progress. What do you anticipate in relation to primary care? There is quite a substantial jump in funding. You have made the point that a 0.3 per cent increase in spending on community health is quite large and that a 1 per cent increase in spending on primary care is, by definition, even greater. What are your plans for delivering that increase and indicating progress towards it?

Jeane Freeman: Primary care is part of the whole integration agenda and it is a significant driver in shifting the balance of care. Some of the work that is being undertaken in primary care centres around the new general practitioner contract, in terms of producing multidisciplinary teams, additional pharmacotherapy services, physiotherapists and occupational therapists—all depending on what individual GP clusters want—as well as mental health officers, which I have already touched on, and so on.

Significant progress has been made in the delivery of the GP contract. From memory, I think that more than 80 per cent of GP practices now have access to pharmacotherapy services. That makes a significant difference to patients and to the workload of GPs by giving them the time to be the local clinical leader that the contract asks them to be, which will elevate their status. In addition, an increasing number of general practices are becoming teaching practices, which we need, because we have increased the numbers of undergraduate, foundation year and specialist training places in GPs' training in order to increase the number of GPs.

10:15

From a health perspective, primary care is a key driver of integration, but primary care is not just about what goes on in GP practices; it is about how we engage with mental health services—I have mentioned mental health officers—and our ambulance service. In addition, there has been a growth in the number of paramedics and prescribing paramedics, and we have begun the roll-out of hospital at home and moving a number of out-patient services from a hospital setting into a community setting.

That work is under way. We will continue to report on our progress against phase 1 of the GP contract and our discussions with the British Medical Association, which I met last week, on the completion of phases 1 and 2 and the timeframes for that. We will also report on how we are progressing towards the 800 mental health officers, the community link workers and so on. I am keen that we understand all those elements as parts of the whole-system approach, which is why I mentioned that at the outset. Mental health officers, community link workers, the GP contract and multidisciplinary teams are all central to shifting the balance of care.

The Convener: Thank you. Committee colleagues will have questions on all those matters in the course of the morning.

Brian Whittle (South Scotland) (Con): Good morning, cabinet secretary and Mr McCallum. The medium-term health and social care financial framework identified the need for savings of £1.7 billion over the period 2016-17 to 2023-24. What level of savings will be expected of health boards and integration authorities in 2020-21?

Jeane Freeman: As I said in my opening statement, and as you will acknowledge, the increase that the draft budget proposes for boards is greater than what the financial framework says is required. That is a significant increase for those boards, which will go towards closing the overall funding gap that the framework identified. I ask Mr McCallum to deal with the specifics of your question.

Richard McCallum (Scottish Government): On the savings that health boards are required to make in 2020-21, we are still working through boards' financial plans. The timing of the budget has meant that agreement on boards' annual operational plans is slightly later than in previous years, but what we have heard back initially from boards is that they are looking to make savings of around 3.9 per cent in 2020-21. To give the committee some idea of how that compares, that is broadly equivalent to the savings that boards had to make in 2019-20 and a bit less than what it was in 2017-18 and 2018-19, when it was closer to 5 per cent.

We track that savings target very closely, and that is a key part of delivering the medium-term financial framework. As the cabinet secretary said, part of that is about additional investment going into the system and part of it is about the on-going delivery of recurring savings that boards and integration joint boards need to make.

Brian Whittle: The cabinet secretary mentioned that an additional funding gap of £159 million was identified in the initial financial framework, and suggested that the current financial settlement had gone some way to closing that gap. Have you identified the means to close the whole gap, or have we still got some work to do on that?

Richard McCallum: The framework runs through to 2023-24, so that £159 million, which I think we said was the size of the gap at the end of that period, is a position that we will work towards up to 2023-24. The steps that will be taken in 2020-21 are a key part of our moving towards that position at the end of 2023-24.

Brian Whittle: The initial figure that came out was £159 million. Given the new financial framework, where we are now? In your previous answer, you suggested that the financial settlement for health boards had gone some way towards finding that extra £159 million. I am interested to know where you think we are sitting just now.

Jeane Freeman: The boards' allocation, which is over and above what is recommended in the medium-term financial framework, will contribute to closing that overall funding gap, but as Mr McCallum said, a number of different elements are needed. Working through health boards' annual operating plans, including their financial plans, will help us to understand how close we are to reducing that gap of £159 million. We will continue to work through that this year and in the budget for the following year. When we see boards' monthly financial reporting, we—and the committee—will be able to see what progress we are making towards finding that £159 million.

Brian Whittle: In your answers to the convener, you talked about shifting the balance of care from hospitals and looking at better regional working and other public health measures. What savings do you expect from that shift and those measures?

Jeane Freeman: As I have said before, when the health service as a whole moved from institutionalised care for people with learning disabilities and other disabilities to care in the community, it was in the fortunate position that it could fund, in effect, a degree of double running—institutions were kept open while the community provision was built up. That has not been an option for us in shifting the balance of care, so we need to make the shift and invest in primary care and integration before we can see what that means for the demand on acute services.

We can anticipate what we think that will mean, in terms of the number of conditions that can be treated in the community as opposed to requiring acute hospitalised care and how hospital stays can be shortened, but other factors come into play. For example, in orthopaedics in Fife, we are now seeing day hip-replacement surgery. That is a significant shift in hospital stays, which plays into the number of beds that are needed and how we maintain the right number of beds to cope with peaks in demand—for example, over the winter period.

A significant piece of work needs to be done before we can say that, by shifting the balance of care, we have released a certain amount of money from acute care. I do not believe that we are yet at the point where we could give you a number with complete confidence, because innovation in medical procedures also contributes to reductions in what is needed in the acute setting.

Brian Whittle: Do you intend to publish an update of the medium-term health and social care financial framework that the committee could have a look at?

Jeane Freeman: We have no plans to produce a new medium-term financial framework but, if there are particular areas in the medium-term financial framework that the committee wants an update on, let us know and we will respond quickly—as we always do—either with the update or with a date on which we believe we will be able to provide the update.

Emma Harper (South Scotland) (SNP): I have a wee supplementary to Brian Whittle's question. I am interested in the attend anywhere initiative as part of shifting the balance so that people do not have to make hospital appointments or travel great distances. You will have heard me going on about the 150-mile round trip from Dumfries to Stranraer, for instance. Shifting in the balance of care is partly about engaging in digital technology, including attend anywhere and other things. Will we be able to measure that and see how we can show savings from implementing that kind of technology?

Jeane Freeman: Yes, we will be able to do that over time, as more and more patients use the technology. The roll-out of attend anywhere, or "near me", as it is called in other parts of the country, is growing in pace. I know that you will be familiar with hospital at home, as it is called in Lanarkshire—it comes under other names elsewhere. We have now begun the active roll-out of hospital at home, which does two things: it helps to promote early discharge and aims to prevent hospital admissions of people who have longer-term conditions or are frail and need acute care that does not require to be delivered in an acute setting—although it needs the right clinicians.

Over time, as we understand the numbers who are using those services, we will be able to evidence what we believe is an overall saving in not just costs but patients' time.

The Convener: I have another question on financial planning and strategy. The Scottish Government's first overall medium-term financial strategy, which was published in 2018, contained portfolio plans, including for health, but the second medium-term financial strategy did not. Do you

know what the plans are and have you come to a view on whether portfolio-specific plans will be included in the medium-term financial strategy when it is published in May 2020?

Jeane Freeman: That is largely a question for Ms Forbes, our new Cabinet Secretary for Finance. I am sure that I will have discussions with her, but I am comfortable whichever way she wishes to proceed.

Alex Cole-Hamilton (Edinburgh Western) (LD): I will start by asking about brokerage. We are changing the system: we have forgiven the considerable debt that some health boards had accrued through brokerage, and additional in-year funding will be expected to be paid back. Given that when we wrote off that debt health boards were—arguably—sent a message that the Government will not allow them to fail, what confidence do you have that in-year funding that is given to health boards will be paid back in the future?

Jeane Freeman: Remember that in what we have done, we have given health boards the flexibility of three-year financial planning and discretion in each year to be plus or minus 1 per cent, with the commitment that they break even at the end of year 3. That allows much more normalised financial planning for health boards.

I will let Mr McCallum deal with the detail on how brokerage is handled.

Richard McCallum: Alex Cole-Hamilton asked about confidence. One of the key things for us is that the four boards that had their brokerage written off at the end of 2018-19 had to agree a plan that would return them to financial balance over three years. A key thing for our confidence is that those boards are in line with the trajectories that they set out when they agreed that three-year plan.

For those four boards, 2019-20 is the first year of the three-year return to break-even. All the boards are either on track or are slightly ahead of the planned position for this stage of the year. The key thing for us is to see those boards back in financial balance as soon as possible, but certainly in that three-year period. Once those boards are back in sustainable financial balance, we will work with them to consider how brokerage that they received subsequent to 2018-19 will be repaid.

Alex Cole-Hamilton: Many boards did not receive brokerage in the past few years but might well need it in the future. We cannot predict the financial impacts on boards—there might be increasing demands and unforeseen circumstances. Would such boards not point to the brokerage for the four boards that had their debts written off and ask for similar treatment in the future? What is to stop them doing that? It does not seem to be particularly fair that there was one rule that four boards benefited from, but which can never be extended to any other health board.

10:30

Jeane Freeman: That discussion was had with all boards at the point at which we introduced the provision that Mr Cole-Hamilton described. It is undoubtedly the case—boards have made this point and I completely understand it—that, from one perspective, what happened was unfair on the boards that managed their finances, that broke even and which took some difficult decisions. However, they all understood that it was a necessary step to provide stability and forward sustainability to the health service as a whole. Therefore, all boards accepted that they all have to break even over a three-year period, in a rolling cycle. All boards are working on that basis.

As Mr McCallum said, in addition to being confident about how the four boards concerned are making progress against the agreed trajectory, in that they are either on track or ahead of schedule, there is consistent monitoring and reporting of the other boards so that we can anticipate with board chief executives and finance directors where difficulties might emerge. That means that we can work with them at an early stage on what needs to be done to manage their way through anything unusual in their circumstances.

Alex Cole-Hamilton: I am grateful for that response. Just for the record, are you saying that the Government will not forgive any further brokerage debt that is accrued by any NHS board?

Jeane Freeman: Our clear position with all the boards is that we expect boards, over a three-year period, to manage their budgets so that they end each rolling three-year period in a break-even position. We are prepared to put in substantial resource—in the form of expertise and support—to help boards to do that.

The Convener: Given the three-year framework that you described, will boards be provided with three-year financial indicative allocations?

Jeane Freeman: That is quite hard to do, because our Scottish Government budget is not a three-year budget—for all the reasons that you, convener, and our colleagues know. Boards can operate in the knowledge that the budget for year 2 will not be less than the budget for year 1. They can look forward on the basis that they can make a reasonable presumption that there will be a year-on-year increase. What they cannot know, and I cannot tell, them is what the increase will be.

The Convener: That is understood.

Brian Whittle: I had a meeting with NHS Ayrshire and Arran about 10 days ago. I know that it had significant brokerage and is making good progress against some of the targets. However, at that time it could not quite see how it will get to break-even point by year 3. What will happen to NHS Ayrshire and Arran at that point, if it does not reach break even? Where will it go from there?

Jeane Freeman: It is in year 1 at the moment, so year 3 is two years away. The job of Mr McCallum and his colleagues is to work with NHS Ayrshire and Arran now, looking ahead, to see what is causing that concern and what we can do, with the board, to help it to get to that break-even position. In one sense, it is positive that the board is worrying about year 3 in year 1, because that is better than waiting until year 3 hits. The other side of that is that it allows us at this stage to work closely with the board to identify what is giving it that worry about year 3, and what can be done to assist it to get over its concerns.

Mr McCallum might want to say something more about exactly how we work with boards. Depending on the needs of the board, it can be very intense engagement and support.

Richard McCallum: As you would expect me to say, we work very closely with boards, particularly those that are in financial deficit, for which we have agreed tailored packages of support. For example, people from the Scottish Government's finance team and other directorates have supported the chief executive of NHS Ayrshire and Arran and his senior team with their financial planning work.

As the cabinet secretary mentioned, we are working through the three-year financial plans, and there is more work to be done on that. We will continue to have close engagement with NHS Ayrshire and Arran, as we do with every other health board, to make sure that we are clear on the position and that we are doing all that we can to help and support it as it develops its plans.

Sandra White (Glasgow Kelvin) (SNP): I have a supplementary on financial planning and the writing off of debts and moneys owed. I am glad that NHS Greater Glasgow and Clyde was not one of the boards—that is good. However, debt was written off. I assume that talks are continuing about the issue. Has it been identified why the boards in question did not meet the criteria? Mr Whittle mentioned NHS Ayrshire and Arran, which was in bother previously and appears to be in bother again. Are talks going on with a view to finding out why those particular boards found themselves in difficulty? Has it been identified where overspends were?

Jeane Freeman: It is not fair to say that NHS Ayrshire and Arran is "in bother again." It is on trajectory, but it is worried about whether it reach break-even by the end of year 3. That is the situation as Mr Whittle described it, and we have described what we do with that board and any others in that position.

Notwithstanding the additional investment that we are making in health through the boards, all boards are in financially challenging positions. It is not the case that some boards were particularly deficient in their work compared with others—the situation is challenging for them all. Some boards' decisions on how they would deliver services created debt, while it can be argued that other boards made decisions that damaged delivery of services in some respects but resulted in the board breaking even financially.

We must work with boards so that they can make decisions that do not have a negative impact on patient care or access to services, and which also manage the financial challenges. That is largely to do with reform of how boards deliver their services, and some of it goes right back to where we started, which is the need to shift the balance of care.

It is not only beneficial to patients if out-patient services can be delivered more locally, rather than in the acute setting; over time, that represents more efficient use of resources. A number of factors need to be brought into play to make that happen, including workforce planning—planning the rotas of consultants and other staff—ensuring that premises are available and planning timing of appointments and so on. All those factors have to come into play.

As with our integration authorities, all our boards do some things very well indeed, but there are areas in which improvements are necessary. The picture is not the same across the country. Part of our role is to help boards to link with one another where improvements have been made in service delivery that have also proved to provide better value for money. That is on top of the additional financial expertise and support that Mr McCallum and his colleagues can provide.

Richard McCallum: Sandra White is absolutely right, in that the key first step is understanding the driver for a board's requiring brokerage. There might be general factors, but there are sometimes specific factors, too.

In the case of NHS Tayside, with which this committee and the Public Audit and Post-legislative Scrutiny Committee are familiar, the board ran a particularly expensive operating model and was a significant outlier from the rest of Scotland when it came to prescribing, for example. Over the past two or three years, we have done a lot of work with NHS Tayside on its prescribing

practices in order to develop a more efficient approach.

Other specific factors include financial planning and leadership capacity. We work with health boards to understand what the problems are and to provide the tailored support that is needed to get them back to the financial position in which we need and expect them to be.

Jeane Freeman: The model of service delivery and its related financial cost is another area in which the chief medical officer's work in the Scottish atlas of healthcare variation can be of value.

The origin of some of the atlas of variation work is in orthopaedic surgery, in relation to which variations in the length of hospital stay around the country have been identified. When clinicians look more deeply at the reasons for variations, they find that they are often not clinically driven: there is no clinical need for a person to be in hospital for twice as long as a patient elsewhere who has had the same procedure. Following that, one can look at what is driving the additional length of stay that is not clinically needed and take steps to reduce the length of stay, which will produce financial gains that can be invested in other areas of work.

Sandra White: That was comprehensive—thank you.

The Convener: In addition to the question of brokerage, the other challenge for boards is the escalation framework. I am pleased that, since the committee requested that the Scottish Government publish regular updates on the framework, it now does so.

The current position appears to be a challenging one. NHS Greater Glasgow and Clyde, NHS Tayside, NHS Highland, NHS Borders and, in respect of the new Royal hospital for children and young people, NHS Lothian are all at stage 4 of the escalation framework. NHS Lothian—for other reasons—and NHS Ayrshire and Arran are at stage 3. That is quite a substantial number of the territorial health services. What is your view on how that situation has arisen? What is your expectation and what are you demanding of boards in terms of returning to stage 1 or 2 of the framework?

Jeane Freeman: There are various reasons why boards are at stage 3 or 4. Generally, it is because of financial performance, performance in delivery of high-quality care to patients, or a mix of the two. The approach that we take differs depending on which has caused a board to be at a particular escalation stage.

I genuinely believe that the escalation framework is an indicator of active NHS national engagement in improving financial and service performance, which should be welcomed.

There is, in particular when a health board is at stage 4, an oversight board that is chaired by a senior person from the health directorate—the chief nursing officer or chief operating officer, for example—and includes others who are there to help the board to monitor and manage improvement programmes and to make sustainable improvements.

NHS Lothian is at stage 4 because we could not open the new sick kids hospital. There is a programme manager who is directly accountable to me, as cabinet secretary, for the work that she is undertaking. She is working with the board, and the oversight board is overseeing that work. I expect NHS Lothian to be de-escalated from stage 4 as the work progresses, provided that it meets the timeline that I have set out, and provided that the hospital can open safely, with the department of clinical neuroscience opening first, then the rest of the hospital. We want to be assured that lessons have been learned.

10:45

As boards' financial performance moves consistently and steadily along the trajectory of the plan that Mr McCallum set out, an assessment will be made of their capability to continue to secure that without being at stage 4. We cannot say that a board will be at stage 4 for a specific length of time. A board will remain at that stage until we are confident that the required improvements are being made and are sustainable.

The Convener: I take it from what you have said that you have set out to each board a timeline for when you expect it to reach sustainability and to return to a lower stage of the escalation framework.

Jeane Freeman: Yes. The boards all have recovery plans that have timelines. They relate to financial performance, as Mr McCallum said. NHS Lothian is at stage 4 because of the new sick kids hospital not opening: there is a clear timeline for that to happen.

As boards make progress, we actively consider whether they can be de-escalated. I am conscious of the value to a board of its progress being acknowledged by de-escalation, and of the value to the service as a whole that boards understand that they can be de-escalated as well as escalated.

However, improvements are required: otherwise, the escalation process is pointless. The escalation process is about bringing in additional support and, depending on the stage, additional

direction in order to secure the improvements that we need.

The Convener: Given that, in their areas, concerns will exist about those boards for different reasons, do you intend to make the timelines public?

Jeane Freeman: For the boards that are at a particular stage because of their financial position, there are trajectories that I imagine are reported in the boards' reporting. People know the timeline that I have set out for NHS Lothian and the sick kids hospital.

NHS Greater Glasgow and Clyde is slightly different, because it was escalated for two reasons. It was initially escalated in relation to infection prevention and control and in relation to information sharing and engagement with patients and families, on which work is under way through the individual case review, as we have reported to Parliament. The board is also the subject of a public inquiry and the independent review that I commissioned about a year ago, which will report in the spring. There is no specified timeline for NHS Greater Glasgow and Clyde in relation to infection prevention and control and engagement.

NHS Greater Glasgow and Clyde was also escalated in relation to out-of-hours provision and other areas of performance. We have put in place a turnaround director, who is directly accountable to me, through the oversight board, which is chaired by John Connaghan, who is our chief operating officer for the NHS. The turnaround director will produce a clear plan of improvements that need to be made in out-of-hours services and in other areas, and that will include a timeline. Again, I will be happy to share that with the committee when it is finalised.

The Convener: So, non-financial timelines will be made available as well.

Jeane Freeman: Yes they will, with the possible exception of NHS Greater Glasgow and Clyde's work on infection prevention and control and engagement, because there is no specific timeline for that, as the work also feeds into the independent review and the public inquiry.

The Convener: I think that Alex Cole-Hamilton has a further question.

Alex Cole-Hamilton: I have several, but they are not on brokerage. I want to ask about a specific budget issue.

The Convener: Okay—but please be brief.

Alex Cole-Hamilton: I am sure that all members of the committee welcome the increase in spending across the health service, but there is one exception. While spending on everything else is going up, why is a real-terms cut proposed in the budget for general ophthalmic services, on which our ageing population will depend more heavily?

Jeane Freeman: You are referring to the 1 per cent increase.

Alex Cole-Hamilton: Yes, but in real terms, that works out as a drop of 0.8 per cent.

Jeane Freeman: The planned spend is £109.5 million, which is just over £1 million higher than the spending in the current year.

I have two points to make in response to the question. First, there are always difficult decisions and choices to be made about where we put the bulk of our spending. Secondly, a number of improvements in ophthalmic services are coming as a result of community-based optometry, which should produce more efficient use of that resource. That is reflected in our planned expenditure in the budget.

Alex Cole-Hamilton: That saving has not come in yet, though, and there will certainly be increased demand. I visited my local optometrist on Friday, where I learned about the preventative work that optometrists do that results in long-term savings, for example by stopping macular degeneration and providing help quickly. Pardon the pun, but does the proposed reduction in the budget not seem like a short-sighted cut?

Jeane Freeman: The work of optometrists is not simply preventative. They can also provide directly some care that is currently provided by ophthalmology services to out-patients in acute settings. The work that they do is more than preventative. We have an excellent optometry service across Scotland, which is currently underutilised not just in terms of the skills that it has to offer, but in terms of the investment that has been made in the service and which the service has made in itself.

Very soon, work will begin—across three board areas, if my memory serves me right—that will result in increased use of optometry services to treat people, as well as to prevent future disease. That will reduce demand on ophthalmology services in acute settings.

Alex Cole-Hamilton: The cut will, however, be felt by community optometrists, too. They are experiencing increased demand and you are expecting them to do more with less.

Jeane Freeman: I am not arguing with what you are saying, but where, in all the areas of level 3 and level 4 spend in the budget, do you suggest we find the additional resource to put into optometry? In budget discussions, cases that make perfect sense can always be made for additional resource for a number of areas, but

decisions must be made about where that money would come from.

Emma Harper: I have a couple of questions about the NHS Scotland resource allocation committee allocations. We know that the NRAC formula is used to calculate funding for boards, and that it is based on indicators including age, sex, population, rurality and deprivation. In your opening remarks, you said that the boards are the closest to parity that they have been since NRAC was created in 2009-10, so it seems that the Scottish Government remains committed to NRAC parity. Will the 2020-21 allocations ensure that no NHS board is more than 1 per cent below NRAC parity?

Jeane Freeman: The draft budget provides £17 million of additional funding towards parity. That means that no board will be more than 0.8 per cent from parity. In other words, all boards will be less than 1 per cent from parity.

Emma Harper: Is the NRAC formula the best way of determining how the funds are assigned?

Jeane Freeman: The factors that are used in the NRAC formula, such as rurality, deprivation, age and population, are reasonable and are the right factors to consider. Age works both ways, of course: an older population produces particular demands on a health service, but so, too, does a younger population. In some parts of the country there is a growth in population primarily among young people and families.

The difficulty with any formula is that there will, in its application, to some extent always be winners and losers. We have provided additional funding to equalise the position, so that no board is more than 0.8 per cent from parity, in order to compensate for the discrepancies that the formula might produce. I have not received any proposals to change the formula. All formulas deserve a review from time to time, so I am not against reviewing the NRAC formula, but we need to be realistic and recognise that any formula will produce greater benefits for some than it does for others.

Emma Harper: Is the Scottish Government committed to publishing data on the position of the boards relative to NRAC? Will you continue to provide updates on that?

Jeane Freeman: Yes, we will. We will know once a budget is approved by Parliament whether our current draft health budget will have to be changed, and will be able to show each board its allocation and how that places it in relation to the NRAC formula and parity.

Miles Briggs (Lothian) (Con): Good morning. I want to follow up on Emma Harper's questions, because this time last year I asked the same questions about reviewing the NRAC formula. Last year, you said that you would look at that, cabinet secretary.

Historically, NHS Lothian has been underfunded by £365 million over the past 11 years. Lothian has the fastest growing and the fastest ageing population in Scotland. You know about the pressures on social care because of NHS Lothian having the highest level of delayed discharges; it now also has the highest birth rate. NHS Lothian has warned us that it cannot run its services based on the NRAC formula.

Jeane Freeman: NHS Lothian will receive £13 million of the £17.1 million that we have put into the draft budget as additional funding in relation to parity, which is the most that any board will receive by far. The next closest is NHS Fife, which will receive £1.8 million to take it to 0.8 per cent from parity. NHS Lothian's position as regards some of the factors that you outlined is recognised by the fact that it will receive £13 million out of that £17 million, which is miles ahead of what any other board will receive. I would probably dispute NHS Lothian's figures in relation to its historical claim, but that is a different matter.

The other issue relates to the position that Mr Cole-Hamilton and I reached on a different matter—ophthalmology—which is that if there is a case to be made for NHS Lothian to receive more than that £13 million, I would have to be advised of where else in the health spend, which is detailed down to level 4 in the budget, that money should come from.

11:00

The fact of the matter is that bringing all boards to NRAC parity without taking money away from any of the boards that are ahead would cost £1.3 billion. If we did it by taking money off boards that are ahead of parity in order to redistribute it, NHS Greater Glasgow and Clyde would lose £35.8 million; NHS Western Isles would lose £8.7 million; NHS Dumfries and Galloway would lose £7.6 million; NHS Borders would lose £0.9 million; and NHS Shetland would lose £0.4 million.

Those are the choices if we simply work within the formula, but if we do not want to do that, and we want to find additional money for any particular board for any reason, we must decide from where else in the budget we will take those funds. Will we take them from integration, from waiting times or from mental health? We must remember that there are a number of fixed costs in the NHS, so we have limited discretion in how we allocate resources.

Miles Briggs: With respect, cabinet secretary, these are your budget decisions. The Scottish Parliament information centre briefing suggests

that the cost of finally closing the gap, lifting every health board up and achieving parity would be £53 billion. Do you recognise that figure?

Jeane Freeman: No, I do not, because the figures that I have just given you are the figures that my officials have calculated and they are the figures that I work with. At the end of the day, the Scottish Government's budget will be the Parliament's budget, so it is incumbent on all of us, if we wish to suggest different priorities for resources, to be clear about not just where more money should be spent but where it should come from. That is the responsible approach of all parliamentarians.

The Convener: From memory, I recall that Nicola Sturgeon was the health secretary who gave a commitment, when NRAC was first introduced, to work towards 100 per cent implementation. From the way that you have described the funding allocation to NRAC this year, it sounds as though you are working towards 99.2 per cent implementation.

Jeane Freeman: No. We would work towards 100 per cent, as the former health secretary and current First Minister said. However, within the overall resources that I have, through the decisions and choices that I have made, I have moved all boards to within 0.8 per cent from parity.

The Convener: Do you have a timeline in mind as to whether and when 100 per cent will be achieved?

Jeane Freeman: No. I could say, "As soon as possible," but I accept that that is not a particularly satisfactory answer. We are working with one-year budgets, so it depends on where we are in a year's time, when we will look at the following year's budget. However, the commitment is there, alongside the other commitments that we are working towards on mental health, waiting times and so on.

David Torrance (Kirkcaldy) (SNP): Good morning. The health capital budget is to increase by £92 million in 2020-21. What are the priorities for the forthcoming capital investment strategy? When will it be published?

Jeane Freeman: We were waiting for the report from the Infrastructure Commission for Scotland to ensure that our capital investment strategy took account of what it said. From memory, the commission reported in January, so we are reviewing our capital investment strategy to ensure that it takes account of the commission's approach. Our intention is to publish the strategy by the Easter recess or immediately after it.

I will let Mr McCallum deal with the priority areas.

Richard McCallum: We are particularly focused on three or four things in the capital investment strategy. The first is to have an assessment of our current infrastructure, where that is, where our commitments are and where we are currently spending money. For example, in 2020-21, a lot of the additional investment will be around the new investment in the Baird family hospital, the ANCHOR centre and the elective centres.

Within that policy context, the focus of the strategy will be on where we see the investment being required over the next 10 to 15 years as part of our longer-term plans. There are some key things that we are thinking about—we have already mentioned attend anywhere. The process cannot just be about investment in new hospital estate; it must be much broader than that. We are thinking about our local care plans and how we invest in primary care, as well as how we make better use of digital technology. That will form part of the plan.

Those are the key things that we will look to draw out. Picking up on what the Infrastructure Commission said in its report, there is the issue of how all that relates to our climate change target for the NHS in Scotland to be net zero carbon by 2045. Some of the information on that will be fleshed out as part of the capital investment strategy.

David Torrance: Are there any plans to use revenue finance to fund capital investment in health facilities?

Richard McCallum: No. In 2020-21, it is all core capital funding that we are using, and there are no plans in the health portfolio for any revenue-financed schemes in the next few years.

Across Government and more widely, there has been consideration of revenue financing schemes and how they would work. A minimum investment model is being looked at in Wales—MIM, as it is known—but there are no plans for any revenue financing schemes in the health portfolio.

Miles Briggs: I want to move on to talk about integration authorities. We have touched on the issue already, but I want to concentrate on access to budget details, which the committee has found difficult. As we move towards decisions being taken by integration authorities, I want to look at the impact that that will have on the Government's targets and services across Scotland.

I make no apology for again talking about the situation in Edinburgh and the high level of delayed discharges there. This week, the Edinburgh IJB is looking to cut £36 million from social care services. As the cabinet secretary has outlined, everyone around the table wants to see a shift from acute to community care. What impact will that have?

Donald Macaskill, the chief executive officer of Scottish Care, said:

"The choices being faced by the Edinburgh IJB are wholly unacceptable."

We have just had a discussion about the NRAC funding. It seems to me that NHS Lothian is being put in a position in which it cannot offer additional funds to the IJB. Where is the joined-up approach to strategic funding?

Jeane Freeman: First, I would want to work with the IJB to better understand why it thinks that it has to make that level of cut to its budget and what is driving that. Secondly, I made a point earlier about joint accountability. Part of the discussion that we are in with COSLA is about how we can use a joint accountability approach that is linked to outcomes and which focuses on priority areas. Delayed discharges would be one of those areas. We need to think about how we can help IJBs to prioritise their spend to deliver those priorities, and how we can intervene and support them when that is proving to be particularly difficult.

Miles Briggs: Are you bringing every IJB to the table to have a discussion before the cuts take place? A simple Google search shows that practically every IJB across Scotland is looking to make such cuts. The impact that that will have on services will clearly have an impact on the targets that we have set for local authorities. Those cuts are going ahead now and it is clear what the consequences will be.

We have had several meetings and discussions about the delayed discharges crisis in Edinburgh. It is getting worse, and we are cutting services out.

Jeane Freeman: We must look at the situation in the round. A number of IJBs are sitting on significant reserves. Those reserves are public money that they were given to spend on a particular purpose which they have not yet spent. Some IJBs—three or possibly four—run an annual deficit, part of which is historical and, frankly, they never get out of the bit. Other IJBs actively manage and deliver a high-quality service, with no delayed discharges and within budget.

This is a joint venture with our local authorities so, along with COSLA, we are actively looking at why there is such a degree of difference. Why do some IJBs—operating within a budget that is delivered to them on the same basis that it is delivered to others—produce no delayed discharges and deliver a high quality of service with high retention of staff, without running a deficit or sitting on significant reserves? What is happening in those IJBs with the transformation and reform of service delivery that is not happening elsewhere? Bearing in mind that social care is delivered by local authorities directly or under contract, how do we use the levers that we have to help all the others to achieve the standard that the best are already reaching?

That process is under way, but it is a process of negotiation, because the delivery of health and social care integration is a partnership exercise between the Government, the health service and local authorities.

Miles Briggs: I respect that description of the situation, but the issue on the ground in Lothian, with Edinburgh's overheated economy, means that it has specific needs. Given that one IJB accounts for about 40 per cent of the delayed discharges in Scotland, it is clear that a solution has not been forthcoming. We are just cutting out potential solutions at the same time as we are losing social care capacity beds.

Jeane Freeman: That requires direct engagement from my officials and COSLA. My officials are directly engaged and I hope that, as a consequence of the discussions on the budget, COSLA will also engage directly with the local authority and the health board on the situation that you describe to help us to find the right sort of transformational route out of that difficulty.

I accept that Edinburgh is a particular case, given the nature of its economy and the population drift into the city and the surrounding areas. However, we need to see the same level of shared accountability across the local authority as we have across the health service.

Miles Briggs: We have also been looking for further detail on the funding allocations to and the outcomes focus for drug and alcohol partnerships. It has been difficult to audit that funding and the outcomes associated with it. What reforms are in the budget to help you to look at that? Will you ask Audit Scotland to audit outcomes for drug and alcohol partnerships? Given that we have a drug deaths emergency in this country, what inspection regime might you develop for alcohol and drug partnerships?

Jeane Freeman: As you know, we have allocated an additional £12.7 million to this area of work on top of the baseline funding in health boards, which, from memory, is £53 million. That is a significant amount of money. Obviously, the health boards report directly to us and we can see exactly what they are doing. As you have said, the difficulty lies in areas where the IJBs are responsible for the level of reporting and the timeous nature of that reporting.

We have made some improvements in the past year, and we are looking to making further improvements with regard to the set of outcomes on which IJBs will report. We are still to reach agreement with COSLA on what those outcomes will be. It is reasonable to presume that a

reduction in delayed discharges will be one of them, but the use of drug and alcohol funds could reasonably be another, with IJBs reporting directly on how those funds are being spent and, more important, the outcomes that are expected. All of that will feed into the work of the drugs task force.

Once we have secured agreement on all of those, I will be happy to make sure that the committee knows what we have agreed with COSLA and the frequency with which we will look at reporting on spend and on outcomes.

11:15

Sandra White: I will go back to the integration authorities, which are important. As the cabinet secretary said, there are so many aspects, such as physiotherapy and so on.

Time is short, so I will get to the questions. We all agree that integration authorities are crucial to the delivery of health, not just to the patients but to the general public in Scotland. Concerns have been raised about the leadership of integration authorities and why they are not responsible for the budgets. Sometimes, the health service or local authorities are responsible. I will get straight to the point. How is the Government addressing those concerns about the leadership of integration authorities and, in particular, concerns that the integration authorities do not have effective control over their budgets? Do you have evidence of integration authorities that have good leadership and control over their budgets? Do you identify what underpins their success? Can other integration authorities learn from that?

Jeane Freeman: Do we have evidence of integration authorities that are successful in terms of their budget and their overall leadership? Yes, we do. Without exception, those integration authorities successfully deliver against delayed discharge and in other areas, because all that goes together. With regard to leadership, there is an organisation of chief officers of integration authorities. I cannot recall its name but it meets in conference every year and undertakes a lot of work. It is about sharing good practice. The chief officers of the integration authorities meet regularly. Along with Councillor Stuart Currie, I was with them on Friday just past, and we work with them as closely as we do, for example, with the chief executives and chairs of health boards.

We have opened up many of the leadership programmes that the health service runs to the chief officers of the integration authorities. Some of the work is also undertaken by the Society of Local Authority Chief Executives and Senior Managers—SOLACE—to ensure that chief officers can be part of those leadership programmes. With the support of SOLACE, we are also looking at ideas of mentorship among chief officers. In the past year, a lot of work has been done on leadership, training and support. Although they are not perfect and they have areas where they want to improve, for integration authorities that are effective, it comes down to the quality of relationships between the parties that are involved—the local authority, the health board and the integration authority.

A year ago, I talked to the committee about issues of legality and governance being a proxy for not doing the job. Integration authorities have moved away from that now. I hear little by way of, "If the governance was only better, we could do X or Y." People are more focused on what needs to be done in order to deliver outcomes. As in any area, when they understand each other's practice more, outliers no longer want to be outliers. They want to improve, so that they are aligned with others.

Sandra White: Earlier, we talked about the budgets. Will the Government commit to presenting integration authorities' budgets every four weeks, rather than every 10 weeks?

Richard McCallum: We provide the information every quarter, about 10 weeks after the quarter's end. We get monthly updates on health boards' positions. Along with COSLA, we want to work with chief officers and chief finance officers, to agree an approach whereby we could get that information regularly.

Sandra White: It would be helpful if it was there before rather than after the budget.

Jeane Freeman: I understand that, but at this point it would not be possible for us to commit to four weeks or any other period because, as Mr McCallum said, it is a joint venture with COSLA and we need to negotiate an improvement on the current situation.

The Convener: A commitment to an improvement is certainly welcome.

Emma Harper: I am conscious of time, but I am interested in set-aside budgets. As I have mentioned previously, there are some boards, such as NHS Dumfries and Galloway, that work with one local authority, so they do not call it a set-aside budget. We have heard evidence that some boards are managing set-aside really well and others are not. Has any action been taken to address concerns about set-aside specifically? What can we learn from those authorities that are managing set-aside really well?

Richard McCallum: That links to the previous question. Set-aside is working effectively where there is clear agreement across the system about priorities and people are involved in decisions on budgets, including the set-aside budget, across

health boards, IJBs and local authorities. Dumfries and Galloway is a good example of an area where the set-aside budget is fully delegated to the partnership, which means that all hospital services are delegated. That is working well. We are seeing it work well in other places such as Grampian, which has a good understanding of what the set-aside budget is and, rather than getting into the nuts and bolts of the detail, is considering what services and care can move out of the hospital setting into the community.

On Emma Harper's point about what happens next and how we can share that learning, at the end of the financial year we will undertake another review of where the IJBs are in implementing set-aside budgets. We will take the good practice that we are seeing in some places and share that with the chief finance officers and our local authority and health board partners.

Alex Cole-Hamilton: I want to ask about mental health funding. We can see from the metrics that mental health funding is going up, but we know that, downstream, there is a problem with recruitment, because we are nowhere near to getting the 800 link workers that the Scottish Government had suggested it would recruit to GP surgeries. Can you speak to how the budget will work on the ground and how we can realise our aspirations for mental health provision?

Jeane Freeman: I apologise if I have picked up your question wrong—if so, please stop me. We are on track in recruiting the additional 800 mental health workers. I have determined that we will introduce an additional focus on the places where those mental health workers are appointed, so that we can ensure that we see more of them in general practice, in accident and emergency settings and, as we talked about in the overall commitment, custody settings.

What I am understanding better, following discussions with Police Scotland, is that it might not be custody settings specifically where the addition of a mental health officer or professional psychiatric input would be best for the police—it depends on the size of the custody setting—and that sometimes it would be better to have that person with them or available to be called on by them so, for example, they are not spending time in A and E or other places where that is not the best use of a Police Scotland resource.

As we look to implement the draft budget for 2020-21, we are looking at how we can target the deployment of the remaining numbers of mental health workers that we need to recruit to get to our overall target of 800 to ensure that we are filling any gaps.

Alex Cole-Hamilton: We understand that one of the principal drivers of excessive waiting times in child and adolescent mental health services is the recruitment deficit. What additional work can the Government do to close that gap?

Jeane Freeman: One of the key drivers of long waits for child and adolescent mental health services is the absence of earlier intervention and support, which results in periods of crisis and referrals to CAMHS that are not appropriate for CAMHS. That is why the investment in school counselling services and additional school nurses that is contained in the budget and which we will roll out in the coming year will make a difference to the levels of referral to CAMHS. The question then is about the long waits of people who are already on the waiting list. Quite a lot of work has been done to increase the recruitment of practitioners to CAMHS. Ms Haughey is doing some work to look at what other professional input to CAMHS can be made that would then be used appropriately for different types of referrals. Does that make sense?

Alex Cole-Hamilton: It does. You made the point about early intervention, which I absolutely accept. I met Children 1st yesterday. Although it supports the aspiration to recruit mental health counsellors to Scottish schools as you have outlined, it expressed grave concern that there are not sufficient numbers of trained counsellors with the necessary skill set to provide that service in schools and that recruitment might become an issue down the line. Do you share that concern?

Jeane Freeman: We are looking at what more we need to do to secure the availability of that trained and skilled workforce; just as we are doing when we say that we want more GPs or allied health professionals, we are considering what we need to do to produce those people.

Miles Briggs: All of us recognise the amazing work that the third sector does on drugs and alcohol but also on mental health. Some of the concerns that are often raised relate to access to funding streams and future proofing services. Is there any talk in the Government or local authorities about three-year planning for third sector services, too? I know that some of the problems that many MSPs have come across have been about funding streams and the constant fight for funding that the third sector often raises with us.

Jeane Freeman: There are two parts to that question. About two years ago, Angela Constance, when she was Cabinet Secretary for Communities, Social Security and Equalities, gave a commitment to three-year funding for the third sector and introduced it. That commitment is in place and has not been resiled from. There is another issue around funding, which Mr Briggs raised in a debate in Parliament, which is about small amounts of funding for very localised voluntary organisations that have a particular patch—they

are not national in any respect and have no wish to be. Such organisations need small levels of grant that allow them a degree of security, while they do all the other things that they want to do and which are part of the way in which they operate, such as fundraising. Mr Whittle has raised the issue in relation to my constituency, too.

We are looking at what we can do to minimise the bureaucratic burden of applying for grant funding of any size, so that smaller organisations can access relatively small sums of money quickly that will give them that degree of security. Such organisations provide an exceptionally valuable resource in their areas.

Miles Briggs: Is that something that you can look at? I have visited GP practices where link workers are doing a good job, but the capacity out there does not exist, so much of their work is to set up men's sheds, gardening clubs, walking clubs and so on, for their community. The People's Postcode Lottery provides a lot of that initial funding for start-ups. Could you look at trying to set up a similar fund or encourage organisations to set up such a fund to make those groups sustainable?

Jeane Freeman: Without making any absolute commitment, I am always happy to consider such ideas. Our football clubs and the community work that they do are among the greatest resources that we have in Scotland. That work links very well with social prescribing and work elsewhere in the Government on loneliness and isolation, and it is spreading as football clubs learn from one another about what they might do, become involved in work around men's sheds, and reach out on dementia and other issues. That work is a huge resource that needs to be remembered when we look at the capacity that is available in any local community.

11:30

The Convener: That is a cue for Brian Whittle to ask about sport.

Brian Whittle: Cabinet secretary, the budget document states:

"Being physically active is one of the best things we can do for our physical and mental health, helping to protect us from many of the most serious long-term health conditions, and contributing significantly to physical and mental wellbeing."

You also said that in your opening statement. In an increasing health budget of over £15 billion, you have cut the sports budget by 1.6 per cent, to £45 million. How can you reconcile that initial statement with the fact that the sports budget has been cut?

Jeane Freeman: Funding for sportscotland increased for two consecutive years. As I said to colleagues earlier, difficult decisions have to be made at times. Sportscotland does a particularly important job. We have increased its funding for the past two years, and the funding is at a standstill for this year, but we have maintained our commitment to underwrite any drops in lottery funding that it experiences. As I said, the work that it does is important, but so, too, is the work that our local authorities do in some areas through their leisure trusts in the links that they make through social prescribing. We are increasingly seeing that in some parts of the country. Social prescribing is linked directly to the leisure and recreation facilities offer from local authorities.

I will give members an example. The work on hypertension that has been undertaken in East Kilbride through primary care using digital technology links directly to social prescribing. An interesting part of the evidence that is being produced is that, when the individual no longer needs health intervention for high blood pressure, they maintain the physical activity that they undertook in order to manage the high blood pressure.

A very useful connection is also made in East Ayrshire. I am sure that members are familiar with the work with the leisure trust that is under way there under the leadership of Eddie Fraser in linking what is going on in primary care, social prescribing, schools and East Ayrshire Council leisure facilities.

Brian Whittle: I sat down with Eddie Fraser last week to talk specifically about that.

The reality is that the sports budget is not standing still; it is being cut by 1.6 per cent. There is no logic in what you have just said. You can accept either that we should shift the balance of care and deliver services upstream or that a multitude of conditions, such as obesity, type 2 diabetes and muscoskeletal conditions, will appear in the ledger downstream. You can either accept what the budget document says about physical activity being

"one of the best things we can do for our physical and mental health"

and invest in that, or accept that that is not one of your priorities—you cannot do both.

In November, you said that there was a real call and a real need for social prescribing. In our report and in the debate that we had last week, we called for 5 per cent of the budget to be spent on social prescribing. If the sports budget is cut, where will the money come from to deliver on your ambition?

Jeane Freeman: The world is not quite as binary for me as it seems to be for you, Mr Whittle. You will see upstream investment in education in the work with young people in schools on nutrition,

healthy eating, diet and activity through the curriculum for excellence. That does not come from the health budget; it comes from elsewhere in Government as well as from local authorities. Much of the activity in social prescribing is not from the health budget but from, for example, the football clubs that I talked about, the third sector organisations that Mr Briggs mentioned and others, such as the leisure trusts of our local authorities.

Although it is not directly from the health budget, if you add all that together, there is significant Government investment in encouraging all of us to make the right choices about diet and exercise and, in particular, in encouraging our young people to develop those habits very early on, and not the bad habits that people like you and I have to try and overturn. I do not accept that maintaining sportscotland on the same level of funding this year as it was on last year is a contradiction in our understanding that diet, activity and so on are important components of a healthier lifestyle and, therefore, a healthier population.

Brian Whittle: Not only are you accusing me of looking at this in a binary sense, when I am looking at it through 40 years of experience, you are suggesting that intervention is happening at education level, but it is absolutely not happening there. You are driving inequalities and, by taking the budget away from sportscotland, which you are charging with the health of the nation, you are acting contrary to what your budget statement says. If you think that sport is as important as you say it is, you have to invest in it, but, in an increasing budget, you have cut it. That does not make any logical sense at all.

Jeane Freeman: I am not exclusively charging sportscotland with the health of the nation. There is a whole NHS health sector; there is public health Scotland, which is due to appear before us very shortly; there is sportscotland; and there is the work that our local authorities do on both leisure and recreation, and in education.

I believe that intervention is happening in education—not consistently, perhaps, as with so much else, but it is happening—so Brian Whittle's charge is unfair. The health portfolio is making a contribution to that important work, but it does not sit exclusively at the feet of the health service and the health portfolio for them to drive forward. I again make the point that, although Mr Whittle is perfectly entitled to want to see increased investment in sportscotland, he has to say which part of the health budget he would take that money from.

Brian Whittle: We can have that conversation.

The Convener: Very briefly, the committee's recommendation on social prescribing was that integration authorities should work towards 5 per cent of their budget being specifically for social prescribing. Does the Government support that recommendation?

Jeane Freeman: It is a recommendation that we are very happy to discuss with the integration authorities, remembering, as I have said more than once, that this is a joint venture, as well as the points that Mr Briggs made about how integration authorities need to address the particular challenges of their budget and set those priorities. However, it is part of what we are looking at with COSLA.

The Convener: Finally, a couple of years ago, the committee produced a report on engagement that highlighted concerns about the engagement of integration authorities. I was pleased to note that the ministerial strategic group on health and community care said in November that statutory guidance is in preparation in order to improve the level of engagement across the board to the level of the best. Will the cabinet secretary indicate when that statutory guidance will be ready and how far it will differ from the guidance that is currently in place?

Jeane Freeman: The statutory guidance that is being worked on covers both health boards and integration authorities—it covers the whole system. My apologies, convener—I had a sneaking suspicion that you would ask me that question, and I meant to check when the guidance would be ready, but I forgot to do so. We will do that straight away and drop you a letter with confirmation of when you should expect to see the new guidance published.

However, I note that it will be different from the existing guidance, which is a bit formulaic and is about the process that you have to go through. As you and I know, genuine engagement is a skill set and an approach that should be backed by a process, but the process is not the driver. The guidance takes an approach that is much closer to what all of us understand as genuine engagement and is about letting communities lead where they want services to go, rather than about a process that needs to be followed to the absolute letter.

The Convener: Thank you very much. I look forward to receiving that further information. I thank the cabinet secretary and Mr McCallum for their evidence this morning.

11:40

Meeting suspended.

11:45

On resuming—

Subordinate Legislation

Alcohol (Minimum Price per Unit) (Scotland) Amendment Order 2020 [Draft]

The Convener: Under agenda item 2, we will consider an instrument that is subject to affirmative procedure. I welcome to the committee Joe FitzPatrick, the Minister for Public Health, Sport and Wellbeing, who is accompanied by Louise Feenie and Julie Davidson. I understand that the minister wants to make an opening statement.

The Minister for Public Health, Sport and Wellbeing (Joe FitzPatrick): I will be as brief as I can. I thank the committee for inviting me to give evidence.

This is largely a technical amendment to the Alcohol (Minimum Price per Unit) (Scotland) Order 2018, which sets the minimum price per unit of alcohol. We have been aware of an issue relating to minimum unit pricing for wholesalers that hold a licence—the issue has previously been raised at the committee. We have considered how to clarify the legal position and decided that an amendment to the 2018 order, which set the minimum unit price at 50p, would be helpful.

The draft 2020 order clarifies the current position that minimum unit pricing does not apply to sales to trade. This is a niche area and concerns only wholesalers that hold a licence. We issued a consultation on the proposed method for clarification and received 11 responses; eight of the 10 respondents who commented on the proposed clarification agreed with the proposal to amend the 2018 order.

Intelligence from national licensing standards officers is that they are content that this is not a live issue in practice and are happy with compliance.

I am happy to take questions from members.

The Convener: Thank you. As will be the case with all the affirmative instruments that we consider today, we will have the opportunity for questions to the minister and his officials. Thereafter, we will move to the formal debate and ask the minister to move the motion. Are there any questions?

Alex Cole-Hamilton: I am grateful to you for introducing the draft order. I was one of the people who, in 2018, raised the issue of the loophole for wholesalers, so I am grateful that that is to be closed.

My question is to do with the fact that the minimum unit price is still 50p. The Alcohol (Minimum Pricing) (Scotland) Act 2012 was passed a long time ago. It was through no fault of the Scottish Government that it was snarled up in legal proceedings, but over the period since the act was passed, 50p is less than it was, in real terms. The impact of that threshold is, arguably, less than the impact that a threshold of 60p would have. Is your Government considering revisiting the price per unit?

Joe FitzPatrick: That is a good point. It is interesting that Wales, which is introducing minimum unit pricing on Monday, has chosen 50p per unit, too. I have said, and I will continue to say, that we need to keep the price under review. We said that we should do that after two years; we are not quite at that point yet. We need to look at the data and consider whether 50p remains an appropriate level; we also need to be mindful of affordability.

There are a number of factors that we need to consider before deciding whether to make a change. I confirm that we will be considering that issue this year.

Miles Briggs: I want to ask about research on the impact of displacement. There has been a decline in cider sales, for example, but an increase in the sale of products such as Buckfast tonic wine. What work have you done on displacement? People are still consuming the same levels of alcohol; they are just not buying the products that they used to.

Joe FitzPatrick: I make it clear that the draft order relates to a very technical clarification of a problem that, in practice, we do not think is live.

On the wider discussion, I was really pleased that, ultimately, all parties supported minimum unit pricing. I am particularly pleased that that has been supported elsewhere on these islands, particularly Wales. The Republic of Ireland is considering the issue, too.

The intention of minimum unit pricing is to deal with the problem that too much alcohol is consumed in Scotland. The latest evidence shows that that successfully reduces the amount of alcohol that is consumed. That is despite a summer that resulted in an increase in consumption elsewhere on these islands.

The specific intention of the policy is to reduce the volume of alcohol that is consumed, and it has been successful in doing that. As a Parliament, we should be proud that we have taken this action, which others around the world are now looking to emulate.

The Convener: As there are no further questions, we move to agenda item 3, which is the

formal debate on the Scottish statutory instrument that the minister has just given evidence on. I remind members that this is not an opportunity for questions; it is an opportunity to speak in the debate and come to a decision.

I invite the minister to move motion S5M-20745.

Motion moved,

That the Health and Sport Committee recommends that the Alcohol (Minimum Price per Unit) (Scotland) Amendment Order [draft] be approved.—[*Joe FitzPatrick*]

Alex Cole-Hamilton: I accept everything that the minister has said about waiting for two years to pass, and I look forward to continuing the discussion later. As it stands, the draft order is an elegant fix to a problem that I helped to identify in 2018. I am grateful to the Government for introducing it.

Brian Whittle: Following Miles Briggs' question about displacement, I will raise one issue. In welcoming minimum unit pricing to Scotland, and the work that has been done on it, we have to be cognisant of displacement not only to other alcohol types, but to cheaper drugs. There is still a little bit of work to be done, and I hope that Parliament will do it.

Miles Briggs: One key aspect of this policy—we all want this—is to reduce alcohol consumption, given the problem that we in Scotland have with alcohol. However, one key aspect that the committee needs to look at is outcomes. The number of alcohol-related hospital and A and E admissions are still increasing across Scotland. We need to look at that collectively.

George Adam (Paisley) (SNP): On the whole, this is one of a basket of measures to deal with our relationship with alcohol in Scotland. It is not the be all and end all, although it has made significant inroads in that people are drinking less. It is a move in the right direction, and one of many other tools that the Government is using.

Emma Harper: The draft order that we are discussing is separate from the issues that has just been brought up. We need to look firmly at the evidence as we progress. There are people who are disclaiming what minimum unit pricing is achieving. We need time for it to embed, and we need to be very clear about the evidence that is presented.

Joe FitzPatrick: Emma Harper is absolutely right that the things that we are discussing are not about the draft order. That is understandable, but the purpose of the order is for the reasons that Alex Cole-Hamilton has mentioned.

George Adam is right that we have never said—I do not think that anyone who supports the policy has said—that it is a magic bullet. It is part of a basket of measures, and the evidence shows that minimum unit pricing is moving us in the right direction.

I think that there is evidence that the trajectory of hospitalisations that we were on has changed, but I am not sure that Miles Briggs's assertion about it increasing is entirely accurate. These are early days, and we expect the health benefits of the policy to take a number of years to come into effect.

It is important that we recognise that the order is part of a basket of measures. Crucially, we have recognised the particular problem that Scotland has with its relationship to alcohol. It is good if we all speak with the same voice on that.

Clearly, it is important that we carry out research that looks at a wide range of factors to do with the implications of the policy. That is happening—a range of research is on-going, which is helping to make it easier for others around the world to follow suit.

Motion agreed to,

That the Health and Sport Committee recommends that the Alcohol (Minimum Price per Unit) (Scotland) Amendment Order [draft] be approved.

Public Appointments and Public Bodies etc (Scotland) Act 2003 (Amendment of Specified Authorities) Order [Draft]

The Convener: Agenda item 4 is consideration of the Public Appointments and Public Bodies etc (Scotland) Act 2003 (Amendment of Specified Authorities) Order. The minister will stay with us, but his officials will swap over. Joining the minister for this item are Derek Grieve, who is the interim head of the health protection division, and Alison McLeod, who is from the legal directorate.

I invite the minister to make a brief opening statement.

Joe FitzPatrick: You might remember that, last November, the committee had a useful discussion about the Public Health Scotland Order 2019. That order constituted public health Scotland as a new national special health board, which will begin to exercise its full range of functions from 1 April.

This related draft instrument sets out an amendment to schedule 2 of the Public Appointments and Public Bodies etc (Scotland) Act 2003, which lists the specified authorities that are subject to section 2 of the act. Appointments to the specified authorities must comply with the code of practice that is published by the Commissioner for Ethical Standards in Public Life in Scotland.

The amendment that is set out in the draft instrument will enable COSLA to nominate councillors for ministerial appointment to the public health Scotland board. It does so by removing those appointments from the commissioner's remit.

As set out at our previous committee session, the partnership between the Scottish Government and COSLA is a new and intrinsic feature of public health Scotland. Our view is that the levers for improving and protecting public health lie at local and national Government level. Joint decision making between the Scottish Government and COSLA holds the potential to achieve real and sustainable long-term change. By allowing COSLA councillor nominations, the order is intended to reflect that vital partnership in the public health Scotland board membership.

Healthcare is clearly not the sole determinant of our health and wellbeing: we know that social and economic conditions are equally significant. We have focused public health reform on joint action on the many factors across the whole system that determine our health.

As you know, the Scottish Government and COSLA have committed to a programme of reform and three key actions. The actions are: to establish shared public health priorities for Scotland; to establish a new national leadership body for population health, public health Scotland, which has been implemented by the Public Health Scotland Order 2019; and to strengthen and support local partnerships to take collective action with communities to improve health and wellbeing.

The collaborative approach to tackling the public health priorities is to be embodied through joint sponsorship arrangements for public health Scotland. Co-sponsorship will provide public health Scotland with an opportunity to support and influence national and local decisions that involve public health. COSLA's participation will emphasise the importance of local delivery in recognising and influencing the determinants of health.

The public health Scotland board will consist of 13 members. The intention is that COSLA will nominate a shortlist of councillor members and that two councillor members will be appointed to the board by the Scottish ministers. This draft instrument is required to remove those appointments from the commissioner's remit and to enable COSLA to nominate councillors for ministerial appointment to the board.

The COSLA nominations are to be councillor members who are recommended for appointment based on merit. For NHS boards, the practice of stakeholder nominations is long-standing, and is intended to reflect specific partnerships. Territorial NHS boards routinely have councillors appointed following local authority nominations. Those appointments are also included as an exception in schedule 2 of the 2003 act, in order to remove them from the commissioner's remit.

The response to the public consultation on public health Scotland supported the principle of COSLA nominations, with some responses noting that the nominations should be made through transparent and appropriate selection channels. We have agreed with COSLA that the national selection process will be merit based, with oversight from the Scottish Government.

Our belief is that the partnership with COSLA will bring better opportunities for innovation and integration across the system.

There is good evidence that, although the NHS has a crucial role, many determinants of health are influenced strongly by local government. By way of joint sponsorship and diverse board membership, we can better influence and support wider local government decisions that will positively impact the public's health.

12:00

The Scottish Government and COSLA, in a new model of collaboration, have jointly contributed to the concept and structure of public health Scotland. I consider that the COSLA nominations will ensure a strong local government voice and perspective on the board.

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

The Convener: Is it your view that this measure will complete the raft of legislative changes that are required in advance of the launch of public health Scotland?

Joe FitzPatrick: Yes.

Miles Briggs: I understand what you have said about transparency with regard to the appointment of the two councillors to the board and the fact that those appointments will be merit based. From our earlier discussion, we know that conflicts can sometimes arise between councillors sitting on IJBs and between councils and health boards. Have you investigated any of that? Given that we do not know what will happen in the future with regard to public health Scotland, have you given any thought to any potential conflict of interests that those two councillors might encounter?

Joe FitzPatrick: It is important to state that all the members of the board are there to represent the board. I think that, in the main, councillors are pretty good at wearing two hats. When the councillors are on the board, they will not be

representing COSLA; they will be representing the board.

The mechanism that COSLA is developing for those appointments is different to what we have seen before. I think that it is the first time that it has taken a merit-based approach rather than just saying that the members must come from one particular party or another. That approach is new and it reflects the degree of partnership that there has been in the development of public health Scotland.

Miles Briggs: That is good to hear. That merit-based approach could be useful in relation to other bodies. Perhaps details of it could be shared with the committee so that we can see what it actually looks like.

The Convener: As there are no further questions from members, will move to agenda item 5, which is the formal debate on the order that we have just taken evidence on. Once again, I remind members that we are no longer in a position of asking questions but of making contributions to a debate.

I invite the minister to move the motion.

Motion moved,

That the Health and Sport Committee recommends that the Public Appointments and Public Bodies etc. (Scotland) Act 2003 (Amendment of Specified Authorities) Order 2020 [draft] be approved.—[*Joe FitzPatrick*]

Motion agreed to.

Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2020 [Draft]

The Convener: Item 6 on the agenda is another item of subordinate legislation. For this item, Mr FitzPatrick is accompanied by Susan Brodie and Anne Mathie from the Scottish Government.

Joe FitzPatrick: Thank you for the opportunity to speak about the amendment regulations.

The draft affirmative order reflects our continued intention to increase free personal and nursing care payments in line with inflation. The order, if approved, will continue to benefit self-funding adults who are resident in care homes. The rates are calculated using the gross domestic product deflator inflation tool, which this year suggests an increase of 1.84 per cent. That will mean that the weekly payment for personal care will rise from £177 to £180, and the weekly nursing care component will rise from £80 to £81. It is estimated that that rise will cost £2.2 million this year. That will be funded by an additional £100 million in the recent 2020-21 Scottish budget for social care and health and social care integration.

The latest available statistical report is for the financial year 2017-18 and it shows that more than 10,000 self-funders benefited from receipt of free personal and nursing care payments.

I am happy to take questions on the regulations.

The Convener: Thank you. Are there any questions on the instrument, which the minister has described as a regular uprating as required by the original act?

Members *indicated disagreement.*

The Convener: As there are no questions, we move to the formal debate on the instrument. I ask the minister to move motion S5M-20741.

Motion moved,

That the Health and Sport Committee recommends that the Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2020 [draft] be approved.—[*Joe FitzPatrick*]

Motion agreed to.

Human Tissue (Authorisation) (Specified Type A Procedures) (Scotland) Regulations 2020 [Draft]

The Convener: The next agenda item is on the final affirmative instrument of the day. It follows primary legislation that was agreed by the committee a few months ago. Joe Fitzpatrick is accompanied by Fern Morris and Claire McGill for this item.

Joe FitzPatrick: Thank you for the opportunity to set out the context in which the instrument has been laid. The Human Tissue (Scotland) Act 2006 was amended by the Human Tissue (Authorisation) (Scotland) Act 2019 to introduce a statutory framework setting out how medical procedures that facilitate transplantation can be authorised, and what conditions are attached to them being carried out.

Those procedures are termed in the 2019 act as "pre-death procedures" and are defined in the act as the medical procedures which may be

"carried out on a person for the purpose of increasing the likelihood of successful transplantation after death"

and which are

"not for the purpose of safeguarding or promoting the physical or mental health of the person."

The Human Tissue (Authorisation) (Specified Type A Procedures) (Scotland) Regulations 2020 set out the procedures that Scottish ministers consider are appropriate to carry out as type A procedures within the framework of section 16E of the 2006 act, as amended by the 2019 act. The regulations list the medical procedures that are frequently carried out in intensive care units at present to facilitate transplantation where donation

for transplantation has been authorised and is proceeding. Those medical procedures are not new: they are required to ensure that donated organs can be matched and transplanted.

Without the ability to carry out those procedures, transplantation of organs is unlikely to go ahead in cases of circulatory death—which is almost 40 per cent of cases. The procedures are very important in helping to ensure that organs can be matched appropriately and that transplantation is as safe as it can be for the recipient.

The regulations are supported by the framework that was established by the 2019 act, which sets out the conditions or safeguards that must be met before the procedures that are specified in the regulations can be carried out. Those include authorisation being in place and the duty to inquire having already been undertaken; that the person is likely to die imminently; that the decision to withdraw life-sustaining treatment has been taken; and that the pre-death procedure is necessary and is not likely to cause more than minimal discomfort to the person or to harm the person.

Those conditions ensure that the procedures that are listed in the regulations cannot be undertaken prematurely. They also reflect the limited timeframe for donation and transplantation.

In practice, if no more can be done to save the life of the patient, and only after the family have come to terms with that, a sensitive discussion about donation will take place. Carrying out the procedures will be discussed in an appropriate and sensitive way, and the duty to inquire means that procedures will not be undertaken before that discussion with the family has taken place.

In developing the regulations, the Scottish Government has worked closely with, and taken the advice of, clinicians who work in intensive care and on the donation and transplantation pathway, in order to ensure that the procedures that are specified as type A will meet the requirements of the act and reflect current practice. I am very grateful for their input. We have also consulted publicly; the draft regulations take into account the responses to that consultation.

I am grateful for the opportunity to provide context on the SSI and am happy to take questions from the committee.

The Convener: Thank you very much.

Sandra White: I took a close interest in the bill when it was being considered by the committee, and I thank the minister for the paperwork that he has provided.

I have two questions. The first relates to the duty to inquire. The minister mentioned potential consultation of a donor's family, but I want clarification on what happens if a donor does not have immediate family. Is the Scottish Government permitted to give consent in such circumstances?

Secondly, do you propose to produce publications to ensure that the public are aware of what happens?

Joe FitzPatrick: It is important to remember that such procedures are routinely carried out at present. An important aspect of the 2019 act is that the duty to inquire has to be carried out, in accordance with the law, prior to the pre-death procedures taking place.

We have already started the process of raising awareness about the change in the law. Folk might have seen posters that are in many pharmacies. We are also doing some radio work.

Fern Morris (Scottish Government): The number of cases in which there are no family members or friends is very small. NHS Blood and Transplant estimates that, in Scotland each year, there might be three to five cases of donors who have no family. As the minister says, the 2019 act includes a duty to inquire, and the guidance will set out the steps that should be taken in cases in which there are no family members or friends.

Sandra White: It is good that there will be guidance. My understanding is that we had a debate about whether the Scottish Government would take over as the family, as we might say, in such circumstances. When is the guidance likely to be produced?

Joe FitzPatrick: The duty to inquire involves checking whether there are no family members. Work is on-going on the guidance.

Fern Morris: The guidance is being developed to inform the training on the new system, which will take place from the spring.

Sandra White: I presume that everyone, including the Health and Sport Committee, will see the guidance.

Fern Morris: Yes—it will be published.

Sandra White: Thank you.

Emma Harper: To clarify, as a former member of a liver transplant team in Los Angeles, I know that it is usual for the listed procedures, which include blood tests, X-rays, urine tests and, potentially, ultrasounds, to be carried out. As the minister has said, such procedures are carried out already.

Joe FitzPatrick: Yes.

The Convener: Excellent.

Miles Briggs: It is good that the regulations have been brought to the committee. During the bill's progress, some of the conversations were

about NHS capacity and theatre capacity. This question does not relate to the regulations. What work has the Government done to assess the potential need for investment in those areas? A specific issue in the Highlands was highlighted during the passage of the bill.

Joe FitzPatrick: We are of the view that capacity exists for implementation of the 2019 act. We have made it clear that we do not expect a massive overnight increase in donation. It is important to be realistic. Parliament agreed that the bill represented the right direction of travel, but I do not think that anyone was suggesting that, in response to the 2019 act, there would be a massive increase in the number of people in Scotland who donate.

The Convener: As there are no further questions, we move to the formal debate on the instrument. I invite the minister to move motion S5M-20837.

Motion moved,

That the Health and Sport Committee recommends that the Human Tissue (Authorisation) (Specified Type A Procedures) (Scotland) Regulations 2020 [draft] be approved.—[*Joe FitzPatrick*]

Sandra White: I thank members of the committee, the minister, the clerks and the people who gave evidence. At times, consideration of the bill was quite harrowing. Everyone listened to the people who gave evidence and to the committee's recommendations. I thank everyone for pushing the issue forward, because the 2019 act is very important. I look forward to the guidance being produced.

The bill received a lot of media attention—I do not know whether that was the case regarding television, but it was certainly the case for radio. Perhaps that medium could be a way of making people aware that change is coming, as well as posters in pharmacies and doctors' surgeries.

12:15

Joe FitzPatrick: The advertising campaign will ramp up as we move towards the autumn implementation date. I think that we are already advertising on radio, but we will bear in mind Sandra White's point and make sure that the widest possible range of people are aware of the change to the legislation.

I thank the committee for its consideration of the matter. It is no surprise to me that there has been more discussion of this issue than of others, given the committee's detailed look at the initial legislation as it went through. I also thank the clinicians who assisted in developing the regulations. Obviously, we will continue to work closely with the clinical stakeholders as we move towards implementation of the act.

Motion agreed to,

That the Health and Sport Committee recommends that the Human Tissue (Authorisation) (Specified Type A Procedures) (Scotland) Regulations 2020 [draft] be approved.

The Convener: I thank the minister and his officials for their attendance.

National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2020 (SSI 2020/17)

Personal Injuries (NHS Charges) (Amounts) (Scotland) Amendment Regulations 2020 (SSI 2020/16)

The Convener: The 10th agenda item is consideration of two instruments that are subject to the negative procedure. The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2020 will amend regulations to take account of overseas visitors entering Scotland who require diagnosis of or treatment for the Coronavirus disease—Covid-19—and to enable that to go ahead quickly.

The Delegated Powers and Law Reform Committee noted that it is

"content with the reasons ... for bringing the Regulations into force"

as quickly as the Government has, but that,

"as required by Standing Orders, the Committee draws this instrument to the attention of"

our committee

"under reporting ground (j) for the failure to lay the instrument in accordance with section 28(2)"

of the Interpretation and Legislative Reform (Scotland) Act 2010, which is about time limits.

In my view, the circumstances justify the Government's action. Members have no comments on the instrument, so does the committee agree to make no recommendation?

Members *indicated agreement.*

The Convener: Members have no comments on the Personal Injuries (NHS Charges) (Amounts) (Scotland) Amendment Regulations 2020, so does the committee agree to make no recommendation?

Members *indicated agreement.*

12:18

Meeting continued in private until 12:21.

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