OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 21 December 2021

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 21 December 2021

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
16th Meeting 2021, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

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

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Richard McCallum (Scottish Government)
Dr Nick Phin (Public Health Scotland)
Humza Yousaf (Cabinet Secretary for Health and Social Care)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 21 December 2021

[The Convener opened the meeting at 09:45]

Decision on Taking Business in Private

The Convener (Gillian Martin): Welcome to the 16th meeting in 2021 of the Health, Social Care and Sport Committee. I have received no apologies. The first item on our agenda is a decision on whether to take in private items 4, 5, 6 and 7. Do members agree to do that?

No member has objected, so that is agreed.

Common Framework on Public Health Protection and Health Security

09:46

The Convener: Our second item is an evidence session with Nick Phin, who is the director of public health science and medical director at Public Health Scotland, as part of our scrutiny of the provisional common framework on public health protection and health security. Good morning, and thank you for coming along.

What changes will be brought about by the framework, and how will that affect public health in Scotland?

Dr Nick Phin (Public Health Scotland): [*Inaudible*.]—and develop. One is to improve the exchange of information with England and the other two devolved Administrations.

We will also try to pool data as we look at research issues such as omicron and its potential impact on people's health, to get the answer more quickly and in a more robust way.

The third area to look at is cross-border arrangements. Microbes do not respect borders. We have seen how rapidly severe acute respiratory syndrome coronavirus has spread globally, in common with many other diseases. Making sure that we have good cross-border co-operation, both within the United Kingdom and with the European Union, is going to be critical.

The fourth area to look at is our research priorities, and we should agree a common focus for research.

Those are four potential benefits to the new ways of working. I do not think that anyone would disagree in principle with the objectives. As ever, it is on the application of those that we probably need to do some further work.

The Convener: Yes. My colleagues have some quite detailed questions—in particular, about our role as a committee in the scrutiny of decisions.

An issue that arises from members having looked at frameworks in other portfolios over the past couple of years is the role of the Parliaments of all four nations and their influence on, or knowledge of, the decision-making process. Are you able to elaborate on any potential in that? Where do the Scottish Parliament and the Scottish Government fit into the decision-making process?

Dr Phin: There are four tiers, if you like. The first is what we call the health protection oversight group, which has representatives from the Scottish Government and Public Health Scotland along

with those from other agencies and Governments. It will meet to discuss and agree issues.

The next level above that is attended by me and by Michael Kellet, for the Scottish Government. The health protection agencies and Government officials of the other three nations also attend. That meeting is at a very strategic level, and we will meet maybe two or three times a year to agree the oversight of the plan.

The third level is the English, Scottish, Welsh and Northern Ireland chief medical officers' group. Feeding into that is a ministerial group, the composition of which is still to be agreed and is an important point for resolution.

The Convener: Everything that you have said about alignment in responses to any public health threat makes perfect sense. We have seen that in action during Covid. However, should one of the nations want to have a different response—for reasons that we do not yet know, because we have to take everything as it comes—would the framework allow for that?

Dr Phin: Yes. Clearly, there is still a degree of autonomy for each country. Wherever possible, consensus is the desired way forward, from the point of view of communications, policy and operations. However, as we have seen with omicron, there can be divergence in how each of the four nations across the UK interprets a situation and responds to it.

A key issue is that the health systems of the four nations have diverged and are now quite different from one another. I cannot see how we could have a very rigid approach. It needs to be flexible in order to take account of the various systems.

The Convener: I presume that the response to the Covid pandemic has informed quite a lot of how the framework has been put together.

Dr Phin: Yes. Discussions had started prior to Covid. Brexit had been on the agenda for some time, so work had started on what the framework might look like. My understanding is that the Scottish Government and the agencies that existed before Public Health Scotland had appropriate input into that. I started just under 12 months ago, so I am getting up to speed as quickly as I can with issues and events in Scotland.

The Convener: Thank you. We move to the deputy convener, Paul O'Kane.

Paul O'Kane (West Scotland) (Lab): Good morning to all who are joining us. Following on from the initial question and conversation, my questions will focus on international relations more broadly. To set the scene a bit on the topic, will the approach to international relations that has been set out in the memorandum of understanding be required often? Is that something that we will—[*Inaudible*.]

Dr Phin: Before I moved to Scotland, I worked with what was Public Health England—it was the Health Protection Agency before that—and one of my roles was providing a national focal point both for the international health regulations and for the European Centre for Disease Prevention and Control, which is the scientific advisory body for the EU. I am therefore quite familiar with the processes that are involved.

My understanding is that negotiations are currently on-going for a memorandum of understanding with the ECDC that would allow us access to various scientific committees and networks, to share data both at country level and across the EU. Those things are all currently under negotiation and discussion.

One of the consequences, if you like, of Brexit has been a greater reliance on the International Health Regulations 2005, which were established by the World Health Organization to allow the exchange of information on issues of public health that are considered to be serious. Those issues are not restricted to infectious diseases; in fact, they include environmental issues. That stable platform has been used pending further agreement on access to the early warning and response system—EWRS—of which the UK was a member and to which Scotland fed in by submitting our data directly into Europe.

Paul O'Kane: Thank you for that. I will follow that up, if I may. Is your sense of that perhaps similar to what you said in your first answer—that the aim would be very much to have a more collaborative approach whereby we would come to a consensus instead of having to look to the letter of the memorandums of understanding when they come forward?

Dr Phin: Yes. As the national focal point when I was in Colindale, which is the centre for infectious disease surveillance and control, I saw a tendency for the scientific expertise to rest within PHE. At an early stage, I asked the devolved Administrations to take the lead in various areas, which is something that I would want to see developing in the discussion with the EU around the memorandum of understanding. We are not quite there yet, because the current technical committee has 15 representatives from the UK Health Security Agency but only one from Wales, two from Northern Ireland and three from Scotland. Some work is therefore needed to make sure that we are adequately represented in those technical discussions. However, it is early days yet. As I say, I believe that collaboration is the way forward.

Paul O'Kane: Thank you. That consensus approach and the desire to get it right from the start are really helpful.

In the hypothetical situation that we could not get agreement between the four nations on an international treaty or international concerted action, is it your view that we would need to invoke conflict resolution procedures, or would the UK Government seek to act unilaterally? From the conversation that we have just had, we know that consensus is certainly what we would be aiming for, but we cannot always achieve that. I am keen to get your sense of that.

Dr Phin: I cannot really answer that question. It would be a policy issue determined by the seriousness of the issue, and the Scottish Government would want to take a view on that. I think that it would be invoked at that level. It would clearly try, whenever possible, to get resolution at some other tier in the administrative structure.

Emma Harper (South Scotland) (SNP): Good morning, Dr Phin. I am interested in information sharing. Given that we now have different scientific advisory groups in each Administration, many of the members of which will, I am sure, know each other, we probably want to pursue a collaborative process using non-legislative measures rather than legislative approaches, which is part of the memorandum of understanding. I am interested in how good information sharing is between the four nations. You have said that there are three representatives from Scotland but 15 from England in the group, and only one from Wales and two from Northern Ireland. How is information currently shared if there is a top-heavy input from England compared with Scotland, Wales and Northern Ireland?

Dr Phin: That particular example was the ECDC memorandum of understanding technical group. I mentioned it to illustrate where we have been and the work that we have to do. I would want to ensure that the mix included some of the expertise that we have in Scotland. It is, as I say, early days; the first meeting of the Health Protection Committee took place only a couple of months ago. Although it is not a case of relying on who you know, I do know many of the people involved well and there is a recognition that they genuinely want to collaborate. Therefore, it is about having those discussions. If, in the course of those discussions, we get no further, we will have to escalate matters appropriately.

10:00

Emma Harper: As a former healthcare nurse who worked in operating theatres, I am very keen that clinicians, scientists and experts work together, because it is through knowledge sharing that we will tackle this pandemic and any future concerns with regard to suppressing future pandemics. I know that a pandemic committee has been established in Scotland, too, so there are lots of experts around the table. However, are we good at information sharing at the moment? How can we avoid duplication and different people doing the same kind of work?

Dr Phin: When I look around, I can identify some areas where duplication is occurring, but I think that that reflects where we are with the development of the common framework. One key element is having a common understanding on research and trying to identify areas where one country might take a lead and other countries would come together to support it. We are not there yet, but we need to look at and address the issue. There is sometimes a tendency to forget about things if they are not addressed at the outset, and it is important to ensure that we are involved at an appropriate level and that we can contribute in a meaningful way across the United Kingdom.

Emma Harper: Finally, with regard to surveillance and other data, I think that it is necessary that we look at the number of Covid cases and the behaviour that has, say, led to an outbreak. We hear about people who are, for example, against wearing face coverings. If we are looking at surveillance in different parts of the four UK nations, are we able to make good comparative decisions that show that one way might be better than another? Would that inform our search for the best way of dealing with the pandemic?

Dr Phin: Yes. I can give you a couple of examples. There is the SARS-CoV-2 immunity and reinfection evaluation—or SIREN—project, in which Scotland is punching above its weight. Indeed, I think that we are contributing 4,500 or 5,000 individuals to support the study, which looks at infections in healthcare workers, the impact of personal protective equipment and reinfections and the waning of vaccine effectiveness over time. It is a good example of our working collaboratively. In another example that relates to the new omicron variant, the four countries have fairly rapidly agreed a common case definition, to ensure that we are comparing apples with apples rather than apples with oranges.

There are slight challenges to deal with. The divergence in the development of health services, the collection of data, the timeliness of the data that is collected and the date on which it is reported present a slight problem with regard to getting a truly accurate representation. Wherever possible, though, we definitely share common case definitions in order to make possible the sort of comparison that you have described.

The Convener: Emma, are you happy for me to pass over to our colleagues for some supplementary questions?

Emma Harper: Yes.

Sandesh Gulhane (Glasgow) (Con): There are many research, cancer and other databases that Scotland does not have but that England does. If we were to combine and work together, we would have a much larger and much improved pool of data. For example, there is the fracture liaison service database, which we do not have in Scotland. It makes sense to me to join these things together and have a big database. Will that approach encourage more shared databases and more shared work between our nations?

Dr Phin: The focus of the MOU is health protection, so fractures would be slightly outside its scope, although I see no reason why that could not be developed over time. That said, obviously, the more information we can share, the quicker we can potentially identify issues and problems as well as beneficial treatments. I think that data sharing is something that we should be pushing.

An organisation called Health Data Research UK has been giving Public Health Scotland funding to examine how we can improve our information technology infrastructure so that we can share data with valid researchers across the UK and even internationally. The data sharing initiative is at an embryonic stage but, certainly, the IT capability is within our grasp. The key issues are in ensuring that we comply with the general data protection regulation and that any data is handled appropriately.

I fully support the suggestion, but the area that you are talking about would currently be outwith the remit of the MOU.

Sue Webber (Lothian) (Con): It is nice to see you today, Dr Phin. I have certainly had a lot of correspondence in my inbox about the secondary breast cancer audit, which Scottish patients are not contributing to, so I found that last question from my colleague pertinent.

I would like to ask about the key lessons that the four nations have learned from the pandemic. What policy divergence has there been, what has changed from what was done in the past and are the key lessons reflected in the framework? I am thinking in the context of the research that the Scottish Election Study published last week, which said that there was a poor understanding of the Scottish Government's FACTS messaging compared with the "Hands, face, space" messaging that came from Public Health England. Given what we have heard about collaboration and consensus, do you think that we might be a bit more aligned in the future?

Dr Phin: It is still early days. The first meeting of the Health Protection Committee was, I think, in October. It agreed a work programme that identifies 11 areas, one of which is a review of disease notifications across the four nations. Scotland and Wales have been allocated the lead on that. The work also includes health protection, development of the workforce, education and so on. Communication is not on the list, but I think that one of the key messages from the Covid pandemic is that we need to pay more attention to the behavioural aspects of getting messages out. I was one of the incident directors in Public Health England's Covid response. We recognised at an early stage that assumptions that were being made about communications were not being borne out by research that was undertaken by many behavioural scientists.

One of the key messages is that we should use behavioural scientists and the information that they have developed in a way that helps to communicate messages. I was not in Scotland at the time that you are talking about, so I cannot comment on the approach that was taken. However, the insights from behavioural scientists are certainly key; I note that there are one or two important behavioural scientists on the standing committee on pandemics that has been established in Scotland. We are aware that it is something that needs to be addressed.

Sue Webber: Thank you. That is all from me, convener.

The Convener: Thank you, Sue. I will move on. I trailed the fact that Gillian Mackay would be asking questions about consultation and scrutiny, so I will bring her in.

Gillian Mackay (Central Scotland) (Green): Thank you, convener. The consultation on the framework has taken place. What issues did parties raise during the consultation, and have they been addressed?

Dr Phin: Unfortunately, I am unable to answer that fully. Many of the consultations took place prior to my appointment. If the committee wishes it, I can try to identify answers by speaking to colleagues and will provide that information separately. I am unable to comment on what happened prior to my appointment.

Gillian Mackay: Thank you. It would be good to follow that up at some point, if we can, convener.

The convener touched on this earlier. Will implementation of the framework impact on parliamentary scrutiny and decision making in the policy area? If so, what impact will it have?

Dr Phin: I cannot really comment on that—I am sorry. As I said, I am still familiarising myself with the current system. One of the proposals in the

MOU is that we look at how ministers and Parliament are involved in scrutiny. That has been highlighted as one of the issues that need to be addressed, but the detail is not yet available and discussions are on-going.

Gillian Mackay: Thank you.

The Convener: That seems to be an issue that I can take to our Conveners Group. Obviously, the committee has had common frameworks before it in the past year or so. We can learn a lot of lessons from that, which might inform how we think scrutiny should happen. We will take that issue away for consideration.

Evelyn Tweed has questions on cross-border co-operation.

Evelyn Tweed (Stirling) (SNP): Thank you, convener. Good morning, Dr Phin. Does Public Health Scotland believe that the arrangements in the European Union and United Kingdom trade and co-operation agreement will facilitate adequate participation of the UK in controlling cross-border threats to or from its closest neighbours?

Dr Phin: That is an area in which, prior to Brexit, we had extremely good relations. Many of us knew individual focal points within each of the countries, and the early warning and response system allowed member states to communicate confidentially with other member states to highlight potential issues and even to share information on cases of concern—a case of tuberculosis, for example, when someone left the UK untreated and therefore presented a potential hazard to the country that they were travelling to, or vice versa. The EWRS was a means of country-to-country communication. It was also a means of informing the World Health Organization and the European Centre for Disease Prevention and Control of bigger issues through wider information sharing.

That gap is not fully addressed through the International Health Regulations 2005, but it is one of the areas that is being pursued in the memorandum of understanding with the ECDC. It is hoped that, very shortly, we will have access to a new version of something called EPIS—the epidemic intelligence information system—which will be called EpiPulse. That would allow for timely sharing of information. At the moment, we have access to the EWRS for coronavirus and flu. The mutual benefit for Europe and the UK of sharing that information is recognised.

However, if you look at certain maps of Europe and look for UK data or even Swiss data, there will just be a grey mark. Therefore, there is still work to do to get some of our data integrated in a way that will allow for comparison, which can be fairly crucial in understanding our progress towards controlling and responding to infections.

10:15

Evelyn Tweed: Are there any other gaps that we need to consider or places where we need to strengthen things?

Dr Phin: One of the areas in which we will, I hope, strengthen things through the MOU is scientific collaboration. We had been part of something like 16 special interest groups, which would meet and come up with common approaches to the big infectious disease issues. That process allowed data to be standardised and common approaches to be taken to issues. At the moment, we are not part of those groups unless we have particular expertise that the EU wishes to access, but developing and being part of those networks will be important to knowledge sharing and reaching common understanding. Participation in those expert networks is certainly a gap that needs to be filled.

The Convener: Were those networks in place because of collaboration across the EU?

Dr Phin: Yes—they were supported and sponsored by the ECDC, which provided the secretariat, hosted the meetings and facilitated gathering of the experts in order to reach consensus and to make recommendations on specific issues with regard to the 17 disease areas that were identified.

The Convener: Thank you—that was really helpful.

I will call Stephanie Callaghan, but Emma Harper has a supplementary. I apologise, Stephanie.

Emma Harper: My supplementary is similar to Sue Webber's question about the "Hands, face, space" guidance. We have test and protect in Scotland, while England has had track and trace or test, trace and isolate. What collaborative work will be done on finding out whether TTI, test and protect or whatever worked, and on people's understanding of and adherence to the guidance? It is important that what is contained in messaging is achievable in order to contain pandemics, so I am interested to hear whether there will be any collaboration on behavioural aspects with regard to such important messages.

Dr Phin: With any major incident or pandemic event, what we call a lessons learned exercise will be undertaken. In Scotland, we have already had an internal focus on some of that, but it would be important to do the same thing on a UK basis. I am not aware of any work that is being planned, but it is certainly something that could be picked up by the health protection oversight group or the Health Protection Committee itself if, as I suspect it will be, that is felt to be important in learning lessons for any future pandemics.

An inquiry has just been launched in Scotland, with a lead identified, and there is also the imminent UK, or England, inquiry. That will partly be about understanding what was done and how well it worked. I imagine that fairly detailed questions will be asked along the lines that you have suggested. However, it would be better to start that work earlier, instead of waiting for an inquiry. As I have said, we do not know when the next pandemic will be, so it is important that we learn the lessons for future events.

The Convener: Stephanie Callaghan will ask our final set of questions, on resources.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): Good morning, Dr Phin, and thank you for joining us this morning.

Under the memorandum of understanding, the shared work programme must be delivered within existing resources. Do you feel that that is realistic? Are existing resources adequate? Are there circumstances in which that could become challenging?

Dr Phin: That is an interesting question. If we were to baseline the health protection resource in Scotland, we would be talking about 90 to 100 people, whereas in England there are probably several thousand. There is quite a disparity in that respect.

In the programme that has been set by the Health Protection Committee, Scotland has been identified as the lead in three areas—review of disease notifications, analysis of the four-nations working groups and a look at the evolving science of genomics with regard to collaborations, co-operation and sharing of data sets and information. Those are big pieces of work.

I can speak only for Public Health Scotland, but I have to say that we would be extremely hard-pressed to contribute meaningfully to those pieces of work and reviews. Clearly, we would prioritise that activity, because there has been no review of disease notifications for more than 10 years. We might identify through a review changes that would help to improve things, but I worry that if the current Covid response carries on, our capacity to respond adequately might not be optimal. That said, it is a collaboration between Public Health Scotland and the Scottish Government, so how the work will be divided will clearly need to be discussed.

Stephanie Callaghan: That was very helpful.

The Convener: As there are no more questions, I thank Nick Phin for his time this morning. I suspend the meeting ahead of our session with the cabinet secretary at 11 o'clock.

10:22

Meeting suspended.

11:00

On resuming—

Budget Scrutiny 2022-23

The Convener: Welcome back. Our third agenda item is an evidence session with the Cabinet Secretary for Health and Social Care as part of our scrutiny of the budget for 2022-23. I welcome to the committee the cabinet secretary, Humza Yousaf, who is joined by Richard McCallum, the director of health finance and governance for the Scottish Government.

I have a broad question for the cabinet secretary. How does the budget start to put in place funding for the Government's manifesto commitments from earlier this year?

The Cabinet Secretary for Health and Social Care (Humza Yousaf): Good morning, convener, and good morning to all members who are present. I hope that you are all keeping safe and well. Although I am pleased, as always, to appear before the committee, it is a shame that the session has to be done virtually because of the constraints that are on us. I look forward to being with you face to face.

You asked a really good question, convener. The budget that we have put in place helps us to build on the manifesto commitments that we have already achieved this year. It is important to recognise that, in the first 100 days, we made an incredible amount of progress in meeting our manifesto commitments, including abolishing dental charges for people aged under 26.

We have gone beyond what we promised to do in the first 100 days—for example, we have introduced the paramedic bursary, which members across the committee were very supportive of, and we have put in place the first steps for the national care service. I will no doubt come back to that. We managed to bring forward many other commitments in the space of 100 days, including the pay rises for not just agenda for change staff but doctors and dentists.

There is a lot that we have done in this financial year that we hope to build on in the next financial year, and the budget goes into great detail on that. One of the key, significant reforms that we hope to progress will undoubtedly be the national care service. That will be the biggest public sector reform in the devolution era. We hope that that will be fully operational by the end of the parliamentary session, so we are putting in place the appropriate building blocks for it.

Crucially, we have funding in the budget to help us to progress with the national recovery plan, including the increase to health boards, which I can go into detail on if necessary. That will help to drive the recovery. We need to make sure that we recover as well as deal with the effects of the pandemic.

A lot of resource is going into capital. Members can see some important projects in the capital allocation, such as Parkhead health centre and the Baird and ANCHOR—Aberdeen and north centre for haematology, oncology and radiotherapy—project, and the money to progress the replacement for Monklands hospital, which is also much needed.

I am sure that we will get into the detail of this, but the big uncertainty continues to be the UK Government's lack of transparency in relation to Covid funding. We desperately need certainty on that because, as we all know, we are not yet through the pandemic. This meeting being conducted virtually is testament to that.

The Convener: Thank you. Gillian Mackay will ask questions specifically on Covid-19.

It is very obvious when we look at the budget allocations that the Covid-19 spending last year was significant, but there is nothing against that this year. To put it mildly, there is some confusion about the allocation of money from the UK Government that was announced last week. There is a dispute over whether that is money that has already been allocated and is accounted for in the budget, or is money that is still to come. That will impact on the health budget, because it will, I presume, be allocated to things such as the vaccination booster programme. Can you give us clarity on what is happening there?

Humza Yousaf: I wish that I could, convener. That is exactly the point that you are making. I will not delve too much into what happened last week, but it was extremely poor that those kinds of silly political games were being played in the midst of a global pandemic or, certainly, at the foothills of another wave. When the First Minister got to her feet, there was a press release from the Treasury that claimed that there would be new money, but it was nothing of the sort. Indeed, there was a potential reduction in the consequentials that are coming our way. Those consequentials are vital, as you have rightly said, in dealing with the effects of the pandemic and for the crucial tools that we have in our armoury against the virus, such as vaccinations and test and protect.

On the UK Government spending review, the Covid consequentials were far less than we had expected, given how much has already been spent on fighting the virus and the fact that the virus has not yet gone away. We desperately need certainty from the Treasury about the amounts of money and how the money will be spent. As members can imagine, I push the Secretary of State for Health and Social Care on those issues

in my regular four-nations calls, as do the Welsh and the Northern Irish. In fairness, he is always constructive in those conversations, but there has been no clarity forthcoming, which is deeply concerning.

I do not know whether Richard McCallum wishes to add to that. He is involved in discussions with finance colleagues at an official level.

Richard McCallum (Scottish Government): I have a couple of things to add about next year and the 2022-23 position. As the budget sets out, no formal Covid-19 consequentials have been agreed for next year. However, there are two critical points to make on the issue. Clearly, in relation to the money that we have agreed for the health portfolio, there are a number of things that we are taking forward to respond to the pandemic. The money that we have invested in waiting times improvement is a direct consequence of the pandemic, and we are investing that as well as we can. The money that we have put towards social care is designed to support the overall system, partly because of the pandemic, although it will have a longer-term impact as well. We are doing what is in our power and in our gift to make those decisions now.

The cabinet secretary made a point about the on-going measures in relation to test and protect, vaccinations and personal protective equipment. We are working on those key areas as closely as we can with the Department of Health and Social Care and the Treasury, because they are the areas in which it is likely that we will continue to need quite significant spend and in which we do not have clarity. Some of that is understandable, because we do not know what the future will hold, but those are the areas in which certainty is most needed.

The Convener: Colleagues will dig into that further. As I said, Gillian Mackay in particular has questions on Covid-19.

The programme for government sets out longer-term spending commitments, but there is no medium-term framework in place. That is understandable, because we are dealing with an acute situation. In relation to our scrutiny, will more evidence come forward about informing decisions and the allocation of increasing budgets? For example, we want to keep an eye on the sum of £2.5 billion that has been promised over the course of the parliamentary session, and on the balance of care, with regard to the commitments that more than 50 per cent of front-line national health service spending will go to community health and that there will be a 25 per cent increase in primary care spending. Can you give the committee an idea of the medium-term plans?

Humza Yousaf: That is a fair question, convener. As we have recognised already, the health and social care medium-term financial framework will have to be updated in the light of Covid and other significant changes, such as our work towards a national care service. The framework considers available resource and demands but, obviously, it does not set our budget. Our budget is informed by key policy priorities and the national performance framework, to ensure that commitments and linked budgets ultimately contribute to the delivery of desired outcomes.

A recent study by the London School of Economics and *The Lancet* suggests that 4 per cent real-terms growth in healthcare costs is to be expected, to ensure improving quality of care and terms and conditions for the health and care workforce. That is very much in keeping with the assumptions that underpin the current medium-term financial framework. I have no doubt that that, as well as other independent research, will inform our view. However, there is no doubt that, given the pressures and challenges of Covid, we will have to look at that medium-term framework once again.

The Convener: Thank you. Sue Webber has a supplementary question on that.

Sue Webber: Cabinet secretary, you spoke a bit about the lack of transparency, and you also mentioned “silly political games”. Therefore, I wonder how you would tackle something that has come from our own auditors. Audit Scotland has called for greater transparency, particularly around Covid spending, and has said:

> “The Scottish Government now needs to be more proactive in showing where and how this money was spent”.

That also relates to the underspend of £292 million in the health and sport budget. We have also heard a response to that from Scottish National Party members in Westminster and your Cabinet Secretary for Finance and the Economy that the money has been carried forward. I was a bit concerned about that transparency because, when it comes to Covid spending, we see only one line for that in the budget for last year—it is not broken down into categories at all. That carry forward is not apparent anywhere in the two tables that I am looking at. Where is that carried forward money sitting in the budget that we are looking at?

Humza Yousaf: We can give you the detail of that. We will always look at any Audit Scotland report in great detail and consider its findings. You might have seen that the finance secretary addressed some of the issues in the Audit Scotland report.

On resource, it is important to say that it was well documented last year that very late consequentials that came in in the last few months of the year would have to be carried forward to ensure that vital programmes, such as vaccination programmes, could continue. Vaccination programmes do not stop at the end of the financial year, so we have a budget for the full initiative.

On capital, there is no doubt that lockdown had an impact on the ability to complete projects within the set timescales. Our portfolio was the most affected, along with transport and infrastructure. Contrary to any claims, the economy budget was overspent.

It is important to digest the full detail of the Audit Scotland report. With regard to transparency in the budget, I am always happy to consider members' suggestions about how we can be even more transparent than we are. I might bring in Richard McCallum on that, as he might have more details. If Ms Webber wants to know about any specifics, she can respond after he has spoken.

Richard McCallum: On the information that we provide to Audit Scotland and others, I want us to be as clear as we can be about not just all the Covid moneys that we have spent but our whole portfolio. I engage with Audit Scotland every month to update it on our financial plans and talk it through our position, and I will continue to do that. As a general point for the committee, if more information is required, either on specific funding lines or on the general budget position, we would be happy to provide that information.

11:15

On the point about the underspend at the end of 2020-21, as Sue Webber said, it was £292 million for the portfolio. That relates to two things. The first is the timing of the consequentials, which the cabinet secretary mentioned. In January 2021, we got confirmation of some funding. The timing of that meant that, in order to use that as efficiently as possible, the funding had to be brought into the new financial year. That accounts for the bulk of that underspend.

The second aspect is a bit more technical and relates to PPE spending. We agreed with the Treasury that, for Treasury purposes, we would account for that on-cost but that, for the purposes of the Scottish Government budget, we would show that by way of stock held. That is a bit of a technical accounting issue, but I can provide more information if needed. That increased the underspend, but it was done in agreement and alignment with the Treasury.

The reason why that money does not show in the 2022-23 budget is that it was carried forward into 2021-22—it was carried into the current financial year rather than the future financial year, which is what the budget is looking at.

The Convener: Sandesh Gulhane has questions on health board budgets.

Sandesh Gulhane: NHS Ayrshire and Arran overspent on previous budgets, as have a number of health boards. It also looks like NHS Ayrshire and Arran requires significant transformational change, particularly in acute services. To me, that is a bit of a worry, given where we are at the moment.

My first question is: will you write off health boards' previous budget overspends? My second question is: what is being done with regard to the significant transitional changes that are required in relation to NHS Ayrshire and Arran?

Humza Yousaf: As I am sure Sandesh Gulhane knows, NHS Ayrshire and Arran remains at level 3 on the escalation framework, which is a serious position for it to be in. That is specifically in relation to financial management. As you would imagine, we continue to act in line with level 3 escalation, and we are undertaking scrutiny and the provision of support in line with that framework. Of course, financial recovery remains a priority for those boards, and the focus has been on the response to the pandemic, which has undoubtedly impacted on their financial recovery plans.

We maintain a regular dialogue with NHS Ayrshire and Arran. As you can see from the budget for 2022-23, it is in receipt of additional funding, but we have put in place additional monitoring for that board and the other escalated boards to ensure that appropriate steps are taken in terms of cost improvement and efficiency in advance of 2022-23.

I remain concerned about NHS Ayrshire and Arran and also about NHS Borders and NHS Highland. NHS Highland was recently, of course, subject to a section 22 report in relation to finance.

Sandesh Gulhane: Would you be looking to write off a proportion of the debt that the health boards have accrued?

Humza Yousaf: Again, we will work closely with the boards on how we can support them. We want them to get to a substantially sustainable level. Like any Government, we would always consider writing off the debts of health boards and similar bodies, but that comes at a cost somewhere else in the health budget, and it is incredibly difficult to find that money when we are in a situation in which every penny is allocated.

We want NHS Ayrshire and Arran to be able to stand on its own two feet financially and to have in place the financial mechanisms and controls that can get it de-escalated from level 3 of the

framework. That is certainly what Audit Scotland would expect.

Richard McCallum might want to add more to that.

Richard McCallum: I will add a couple of points.

Dr Gulhane's question is really important. Over the past 20 months, our approach with boards has been about balancing on-going financial management and scrutiny with the realities that they have needed to focus on, such as the immediate issues of dealing with the pandemic. A transformation programme does not happen just in a finance department; it needs to happen hand in hand with clinicians and those who work in the service. We need to strike an important balance between asking boards to continue good financial management, scrutiny and transformational change and recognising, at the same time, the pressures that they are under in dealing with the pandemic.

With that in mind, in 2020-21, we took an approach—we will do so again this year—of not providing brokerage. Instead, we will support all boards with Covid funding, which will allow them to balance their financial position this year, as all boards did last year. We recognise that there is an element of unachieved savings, because boards have not been able to move forward with their savings plans, as they might normally have done pre-pandemic.

The cabinet secretary raised a point about keeping boards that have been financially escalated under enhanced measures, so that we get monthly reporting from them that shows what they are doing with their financial planning. While the pandemic goes on, the transformation work has not stopped, and we have continued to discuss with the boards the steps that they have in place.

Going beyond that, we have asked all boards for three-year service and finance plans for 2022-23 and beyond. That will tie in with the spending review when it comes in in May. That is when we will look to get greater assurance and certainty about boards' financial plans moving forward.

Sandesh Gulhane: I have looked through the details of the money that has been provided to boards, and it appears that the amount spent on distinction awards has come down. Are we still giving out new distinction awards or have they been phased out?

Humza Yousaf: I do not think that we are giving distinction awards. We took a decision not to do that. Richard McCallum might want to provide further clarity.

Richard McCallum: That is correct. The reason why the money is reducing each year is that new awards are not coming in. That budget line will probably continue to reduce, because new awards are not being provided.

Humza Yousaf: It is a number of years since we took that decision.

Sandesh Gulhane: The more detailed table says that the distinction awards are

"designed to provide competitive remuneration packages for consultants and ensure we attract and retain the right calibre ... of employees".

Without the distinction awards, how are we achieving that?

Humza Yousaf: There are a number of other ways that we can look to recruit and retain. Under this Government, there has been an incredible increase in the number of medical consultants since 2006, which we are pleased about. However, I take the point about retention.

We are looking at a number of avenues—one is to make sure that people are well remunerated, and another is to look at pensions. Some of that is within our gift, but a lot of it is within the UK Government's gift, and I have been having discussions with it about potential pension changes. I think that Dr Gulhane is a member of the British Medical Association, so he will probably know that it has written to me about whether the Scottish Government can do more in relation to pension changes that would help with retention.

There are a number of other avenues that we can look at instead of distinction awards, which we have not provided for a number of years. I will work closely with the BMA and others to ensure that Scotland is a competitive place when it comes to not just recruiting but retaining more consultants, which is key to your question, Dr Gulhane.

The Convener: I see that Sue Webber has a question. Sue, I have you down to lead our questions on capital budgets. If you have a supplementary question on health boards, please move on to that theme afterwards.

Sue Webber: I represent the area that NHS Lothian covers and I was disappointed by the distance between its allocation and the NHS Scotland resource allocation committee recommendation—[*Inaudible*.]—£12 million.

Richard McCallum said that you are prioritising funding for health boards that are struggling to deal with the pandemic—to be fair, most boards are struggling with that to some degree. However, the greatest percentage increases are going to the national boards, not the local ones. The national boards include the NHS National Waiting Times

Centre, which provides planned elective services, but the boards that are really struggling are the ones that have accident and emergency departments and deal with emergency admissions.

Why was the decision made to give more, proportionately, to Public Health Scotland, NHS National Services Scotland, Healthcare Improvement Scotland and the waiting times centre, rather than other health boards?

Humza Yousaf: Every health board is receiving an uplift, which is important. I completely accept that you will go out and bat for NHS Lothian, given your role. Why would you not do that? However, every single health board faces significant challenges. When I look at the figures, of course I see that the A and E department at the Royal infirmary of Edinburgh faces a challenge. However, if I look along the M8 to the Queen Elizabeth university hospital, to Forth Valley royal hospital or to Aberdeen royal infirmary in NHS Grampian, I see that A and E departments across the country are under significant pressure and are significantly suffering. Our NRAC formula, including the funding that we use to ensure that boards are within 0.8 per cent of NRAC parity, assists health boards across the country.

The funding to the non-territorial boards is vital. You mentioned the funding for Public Health Scotland. When we think about how crucial that board has been to our fight against the virus over the past 20 months, I do not think that anyone would argue—and you are certainly not arguing—that we should take money away from it to spend elsewhere.

All boards, territorial and non-territorial, are important. We have record investment of £18 billion in the health service. This is the first time that we have been able to finance health and social care to such a level. There is significant funding.

I give you an absolute promise that I meet NHS Lothian very regularly and I have a great amount of faith in the ability of the management team, the chair and the board to put the money to good use to improve what is a very difficult situation right across Lothian.

Sue Webber: Thanks. I have great admiration for NHS Lothian, too.

On the capital budget, you mentioned the Baird and ANCHOR project and the Parkhead health and social care centre in Glasgow. In the past, people have levelled at me the claim that there is not enough investment in building new GP infrastructure across the country. We might get one significant general practice funded in any Government's term of office. Will there be more detail on that in the capital investment strategy? When will that strategy be published?

Humza Yousaf: You ask a good question. As you can see, we will invest a significant amount of money—[*Inaudible*.]—in the Baird family hospital and ANCHOR centre project. That is important. You will also see in the capital funding figures that there is significant funding for Parkhead of more than £30 million in-year. That is our biggest investment in a health and social care centre, which is the model that we want to take forward where it works, albeit that it is not appropriate everywhere.

We know that, in health and social care centres, we can get the appropriate support in one place for the public that they serve. That can be exceptionally helpful, particularly when it comes to reducing demand at the front doors of our acute sites. You talked about that issue earlier. I add that, through our manifesto, we have committed to spend £10 billion on health infrastructure over the next 10 years. That is a really ambitious target, so we will have to ensure that we profile the spend appropriately over the decade.

11:30

You asked about the capital investment strategy, and you are right to suggest that it will be key to some of the important funding decisions. We intended to publish the strategy after the Infrastructure Commission for Scotland published its report on 20 January 2020, but we have, of course, been focused on the response to the pandemic. We therefore do not have a date nailed down, but I promise Ms Webber that the strategy will be published as soon as it can be. She is right that it is an important document that will give people at least some comfort and reassurance that those important capital projects are being taken forward.

Sue Webber: On the £10 billion, you have talked about refurbishing health infrastructure. Does that specifically include technology that is within hospital infrastructure? We are talking about capital, which should include theatre tables, new theatres and buying newer and better technology. I am aware of a specific experience in Glasgow where a hospital was unable to buy a new theatre table or certain pieces of equipment but it was able to lease them at £2,000 a time. That did not make much sense to me when I looked at the number of times that it was looking to rent versus the overall spend. I am trying to gauge what might be possible. I know that the level of capital that gets down to that granular level is not always significant enough to invest in what is needed for services.

Humza Yousaf: We have not yet made any final decisions on how that money will be earmarked, so we have not given full detail of that. We have to look at what the health board wants to fund and whether it could be financed through capital or resource. You mentioned theatre tables as a specific example. Capital projects are, of course, important investments to make. We need to give health boards the ability to renew their equipment where possible. However, the real focus of our capital infrastructure programme will be on significant refurbishment and significant replacement and build of assets.

Richard McCallum may wish to comment on the specifics around theatre tables being—

Sue Webber: That was just an example.

Humza Yousaf: I know. The point that you make is important. I am genuinely not—[*Inaudible*.]—focus on the big projects; there is also a question about smaller projects.

Richard McCallum: It is a really important point. That is just one specific example. The capital strategy that we will produce will include an equipment replacement programme, because we know that that is a challenge and a risk for health boards. That will make sure that boards are working forward with a clear plan and design for those things. Over the past year, we have worked with all the territorial boards to look at their equipment replacement plans, and we have built that into the workings that we have done as part of the capital investment strategy.

The Convener: Paul O'Kane has a supplementary question.

Paul O'Kane: My question follows on from the point about the £10 billion investment over the next decade. Given that health capital budgets are typically around £500 million, it is clear that there will have to be quite a detailed uprating, and I am keen to understand where you think that that will come from. A huge amount of capital promises have been made within that, whether in the plan that has not yet been published or in the manifesto—for example, in relation to refurbishment of the Royal Alexandra hospital and the Vale of Leven hospital in my region. There is already a £76 million repair backlog at the RAH. I am therefore keen to understand how and when we will profile those things.

Humza Yousaf: That is a very fair question. Some of it goes back to what I said to Sue Webber. Given the capital infrastructure projects that we are currently dealing with—the biggest one in my in-tray is the replacement of Monklands hospital—we suspect that most of that money will be backloaded to the latter years of that 10-year spend.

However, that is why the capital investment strategy for health will be published sooner rather than later. I do not have much to add to what I have already said to Ms Webber. I hope that people understand why the strategy was delayed, but I also accept the challenge from elected members that they need some certainty. I guarantee that we are working on the investment strategy and we aim to publish it as soon as possible.

The Convener: We move on to questions on Covid-19 health spending.

Gillian Mackay: Given the new variant, have estimates and identified funding allocations changed in the 2022-23 budget?

Humza Yousaf: It is a developing situation. I go back to my initial remarks to the convener: we are perplexed by the level of Covid consequentials and funding that the UK Government has put on the table. It may be that that is its initial estimate and it will add to that as circumstances dictate, but for us it is deeply concerning.

The omicron variant adds financial pressure, without a shadow of a doubt. I have heard Gillian Mackay speak on the issue in the chamber, so I know that she is well aware that, with additional resource, we could potentially go further with measures to compensate businesses, which are already suffering. Even under the guidance, advice and regulations that are currently in place, businesses are getting cancellations by the thousand, which has a serious financial impact. If there is to be another variant, which we cannot discount, it will add even more financial pressure, so that clarity is much needed.

Gillian Mackay: We have spoken about the lack of clarity about additional funding from the UK Government. If there is additional funding, how do you envisage its being diverted to different parts of the health service?

Humza Yousaf: Part of it would be to give more financial compensation to those sectors that have been hit, and hit hard. Again, I will not pre-empt what the First Minister will say in the next couple of hours, but even with the current position, there is no doubt that not only the hospitality sector, but the events and cultural sectors and others have been hit hard. If we had some greater financial certainty, we would be able to act in the way that we thought was in the best interests of Scotland.

I note again that that is not just an SNP or Scottish Government position; the Welsh Government, which is led by a different political party, has said something similar. The appropriate decisions for our countries should not be constrained by whether we get additional resource from the UK Government. It should be the case that we take the decisions that are in the best

interests of health in Scotland and then the funding flows from the Treasury in respect of those decisions.

We are continuing to bolster test and protect and the vaccination programme as key foundation blocks in our fight against the virus. They are always important and they are being adequately funded. However, to give just one example, I note that we had to push the UK Government really hard for it to extend the contract for the Glasgow Lighthouse lab, which has done an incredible job. The contract was due to run out in March 2022 and we were getting anecdotal evidence that people were going to be looking for other jobs because they had no job security. The UK Government has now moved on that and extended the contract to September 2022, but we should not have to keep pushing it in order to get a level of certainty.

Gillian Mackay: Given the emergence of the omicron variant, the impact that it will have on the recovery of the health service and the uncertainty around that, how do you see that spending around recovery being allocated?

Humza Yousaf: There is no doubt that the omicron variant causes more difficulty. The emergence of a new variant that is more transmissible means that we are facing an even greater challenge.

As Gillian Mackay will know, when the first omicron clusters were found in the Lanarkshire area, we ended up in a position where entire departments in our acute sites in Lanarkshire were worried about staffing levels. They were able to cope, and I pay tribute to the management and the health board for managing the situation, but it looked really difficult and challenging at one time.

The emergence of a new variant not only has direct health impacts—although it has those, and we have to factor that into the recovery—but affects our staff. An exemption process in now in place for NHS and social care staff. However, if a staff member tests positive—and positive cases are increasing, as we see in the recent daily numbers—that will still have an impact on the health service.

The Convener: Paul O'Kane has some questions on social care and the national care service.

Paul O'Kane: I want to get a handle on the figures in the budget. Can you explain the difference between the £1.6 billion, which is highlighted in the budget, and the £1.1 billion that is identified in the budget tables under "social care investment"? I am trying to understand why there is a difference between those two figures and what the actual spend is.

Humza Yousaf: I will have a look at the tables that you are talking about and give you an explanation.

The in-year transfers from the health portfolio to local government are grouped together within the budget as "social care investment" and the detailed elements are then set out in the level 4 budget tables, which are available on the Scottish Government website—that accounts for the £1.1 billion total. The £1.6 billion is the overall package of investment in social care and integration, which comes from a combination of funding that has been baselined in health boards and local government and from further in-year transfers from the health portfolio to local government. That is why there is a seeming discrepancy between the figures, but perhaps we could make that a little clearer. That is my reading of it.

Richard McCallum: That is correct. The £1.6 billion represents all the money that is passed from the health and social care portfolio to social care; about £500 million of that has either already been baselined in local government settlements or as part of an NHS board settlement that will pass through to integration joint boards. The £1.1 billion represents the transfer that will be made in-year. That is the reason for the difference between those two numbers.

Paul O'Kane: It would be useful for further scrutiny if the committee could have more detail on that in writing.

I want to ask about the structure of the national care service. We are still going through the responses and the structure is not yet finalised in respect of the proposal to create community health and social care boards to replace IJBs. Does the cabinet secretary think that many of the issues that have been experienced with financial accountability and leadership in IJBs will be solved by creating a new structure?

Humza Yousaf: That is a good question. First, I would say that there is no fait accompli. As I have said to the committee before, I am not sitting here with a master plan of what the national care service will look like and then expecting the consultation process to fit in with my thoughts—far from it. We are genuinely interested in the analysis of the responses, of which we have received a considerable number.

We also want to ensure that we do not create a system and then try to fit people into it, but that we create a system that fits around individuals. Financial accountability is hugely important, not only for us as decision makers and policy makers, but for the individuals involved. I will not be the only MSP who has had to fight on behalf of a constituent because they have not received a package of care for a loved one or relative and

their fear is that that has been more to do with cost and finances than the actual needs of the individual.

11:45

Again, I emphasise that nothing is concluded yet on the structure that we will end up putting in place—it may be that we will create community health and social care boards. However, financial accountability and leadership, which Paul O'Kane mentioned, have to be central to the creation of a national care service, whatever structure we end up putting in place.

The Convener: Paul, do you have another question or can I move on?

Paul O'Kane: I have just one more question, and I will segue to the subject of pay for social care workers. During the budget process, the finance secretary said that she felt that the 48p increase was fair and "pays carers for their labours"—I think that that was the expression she used. Does the cabinet secretary agree with that? Does he feel that that is an acceptable pay increase for care workers?

Humza Yousaf: Paul O'Kane uses the 48p figure—I appreciate that if I were in his position, I might end up doing the same. However, if we look at what that pay increase means for an adult social care worker over the course of a year, it is not to be scoffed at. We are talking about just shy of an additional £1,000 a year. That is not the only pay increase that we have introduced as a Government or that I have introduced as health secretary. It comes on top of an additional pay uplift from £9.50 to £10.02, which of course was then increased to £10.50.

As we continue to be in the budget process, if Paul O'Kane believes that funding should increase social care workers' pay to £12 or £15 an hour, for example—I am not sure what his current position is—we would have to find that within the allocated budget and such increases do not come cheap. I know that Paul has previously called for an increase to £12 per hour; that would cost £420 million per annum. If we took it to £15 per hour, it would cost £1.3 billion and, once improvements to terms and conditions were factored in, it could cost up to £1.6 billion. Those are not small numbers.

I absolutely take the point that our social care colleagues—those in adult social care in particular—need to be recognised and valued and that is why we have ensured that they get a pay increase and a pay uplift. When it comes to any addition to that, let us have that discussion but let us be up front about where that money would come from.

The Convener: We move on to questions on preventative spend from Evelyn Tweed.

Evelyn Tweed: It is good to see a focus on preventative spend in the budget. How is the Scottish Government ensuring that there is a joined-up approach to spending and outcomes across portfolio areas?

Humza Yousaf: That is probably the most crucial question that we are dealing with at the moment. This Government has progressed the preventative spend agenda for a number of years. It was core to the Christie commission report, which is as relevant today as it was when it was published.

We can do everything that we want to do in health but, if we operate in a silo, we will not make the difference in people's lives that we want to make. We have to make sure that we are working with our colleagues—which we are—across the education, social justice, justice, housing and economy portfolios.

The work that the Deputy First Minister does in bringing us together, at least weekly, with a laser focus on, for example, child poverty targets, helps us to work in a way that is even more collegiate than was previously the case. That will both help us as decision makers and have an important effect on outcomes for those who have, regrettably, fallen through the cracks between the various systems and been passed from pillar to post, which is not acceptable. Good joined-up working is taking place between various portfolios.

Evelyn Tweed: We have heard about all the pressures on the NHS, and we are in the midst of another wave of Covid. How can funding for preventative spend measures be protected?

Humza Yousaf: In all honesty, I think that those two aspects are linked. We can help people through Covid with the various spends that we have already put in the budget. Vaccination is an example. We know from the data that vaccine uptake can be at its lowest among those in the most deprived areas. When we deal with preventative spend by focusing on child poverty and early intervention, that can help our vaccination efforts not just in the current pandemic, but in ensuring that we are prepared for whatever the next pandemic might be. It is important that we do not see those two aspects as distinct and separate; I know that you do not.

With regard to protecting spend, it would be fair to say, looking at our budget in detail, that it delivers on the commitment to direct 50 per cent of front-line spend towards community health services and progresses our commitment to increase primary care funding by 25 per cent. We have a good basis on which to build. I agree that, with regard to current pressures versus what are

seen as preventative measures, it is difficult to get the balance right, but I try not to view those two aspects as distinct and separate. Our investment in preventative measures will also help us to deal with the pandemic.

The Convener: We move on to talk about shifting the balance of spend, with questions from Emma Harper.

Emma Harper: At previous meetings, the committee has taken evidence on shifting the balance of care and moving spend to be more preventative, moving the focus away from hospital settings and more towards the community. The Scottish Government has committed to shifting the balance of care so that at least 50 per cent of front-line health spending takes place in community health services. That commitment is in the budget. Do we now need to be more ambitious, or is 50 per cent adequate for what we are planning?

Humza Yousaf: I like that question from Emma Harper—it is fair to throw down the gauntlet in that regard. If we are already getting there, are we challenging ourselves enough? In my view, it is a positive that we have got to where we have.

The purpose of the target is to make changes on the ground and to underline the Scottish Government's focus on shifting the balance of care where that is possible, while ensuring that we have in place appropriate support for hospital-based services. Nobody would say that—[*Inaudible*.]—which is an important point. I know that Emma Harper has personal experience of this area and understands the issues very well. We will continue to review the appropriate portion of spend.

To go back to my previous comments in response to the convener, once we do some further work on the medium-term financial framework and get further details, we will take that into account. In general, however, Emma Harper's challenge to us is fair, and I will absolutely reflect on whether, if we are already meeting the 50 per cent target, we should be looking to be even more ambitious.

Emma Harper: Sometimes all these budget lines, top lines and different figures just get thrown out there. I am interested in the idea of £15 per hour for care persons. That is what a band 5, three-year university-trained staff nurse makes. If we were going to make a challenge to move or increase that spend, that puts another burden on workforce planning, and that would be a concern for me. I am suggesting that social care staff should be supported and educated to have clinical expertise and progression, but £1.6 billion is an interesting figure that you have given us—if such a measure were to be taken—for a £15 per hour salary. It would be interesting to hear your additional comments on that.

Humza Yousaf: I do not have much to add, although every single person around this virtual committee table will be in the same space when it comes to all of us valuing the role that social care workers have played throughout the pandemic. Dare I say that it should not have taken a pandemic for people to realise just what a significant and important role our social care workers play. Saying that is one thing; rewarding them appropriately is another. In Government, we have a good track record. In the past 12 months, we have increased their pay, effectively from £9.50 to £10.50 per hour, and we are putting up the appropriate finance and funding for that.

I fully appreciate that there are members across political parties who will say that they want us to go further. If that is the case, we will obviously engage with those budget discussions with the Cabinet Secretary for Finance and the Economy, but you must be able to tell us where you take that money from—perhaps from other parts of the health service or social care. Emma Harper is of course right that that could have a knock-on impact on other parts of the workforce, which we have to factor in.

I am always up for having this conversation on what more we can do to reward our social care staff. Let us do that based on figures and based on what is available in the budget. Let us have a realistic conversation about where the money would have to be taken from if other parties want us to go even further.

The Convener: Emma, are you content to let me move on to the subject of mental health?

Emma Harper: I had one more question, about progress towards increasing primary care spend by 25 per cent—I think that the Government has a commitment to increase primary care spend by 25 per cent. I make that my final question.

Humza Yousaf: Yes, we do. Looking at my tables, I see that we are at about 6 per cent. That is a good first step in that direction. You are right: we have that commitment, I would be confident of meeting it, and that is a good step in the right direction.

The Convener: We can now move on to the subject of mental health spending.

Stephanie Callaghan: Good morning, cabinet secretary. First, I will quickly praise NHS Lanarkshire for all its hard work.

Moving on to mental health, I appreciate that, with NHS boards and integration joint boards delivering mental health services, tracking spending can be a bit challenging, particularly for things that are outwith the health sector itself. I

have a couple of questions on that. First, what evidence is being gathered to understand the impact and effectiveness of the additional spend? Secondly, how does that influence future funding decisions—for example, the balance between adult services and child and adolescent mental health services?

Humza Yousaf: Those are both good questions, and they are intrinsically linked.

I agree with Stephanie Callaghan's opening remarks about the job that NHS Lanarkshire has done. It has not been without its challenges. Indeed, there are a number of challenges that NHS Lanarkshire often faces, given its geography and the pressures that it is under. It has coped admirably well. As you can imagine, we are working with NHS Lanarkshire very regularly to see how we can get it de-escalated from the highest level of escalation, which it is on at the moment.

12:00

Stephanie Callaghan makes a good point about the effectiveness of the interventions and of the money that we spend. Any funding that we allocate is delivered against really clear criteria. The recipients of the funding have to report on its impact and on the outcomes that we agree. We have on-going regular engagement with stakeholders around the use of resources to deliver outcomes and what the risks may be. There can be unforeseen risks in a funding application that cannot be accounted for when it is received.

As the member probably knows, we have committed to refreshing our long-term mental health strategy. That work will build on the evidence of success that we have seen from interventions and on engagement with stakeholders and—crucially—people with lived experience, to identify what the future priorities will be. In turn, that will help us to know what our funding priorities should be.

The second part of Stephanie Callaghan's question was also really good. It was about the balance between adult services and child and adolescent services. The first thing to say is—my goodness—what an impact the pandemic will have had on all those services. That is not to say that there were no challenges before; I readily accept that there were. I will not be the only MSP on this call who had a constituent who was in need of and on the waiting list for CAMHS. That list was far too long—I am not going to pretend otherwise—but there is no doubt that the situation has been exacerbated by the pandemic.

Our mental health transition and recovery plan, which was published in October last year, reviewed the priorities. An additional £120 million recovery and renewal fund was allocated to support the delivery of that plan, and decisions on its use were based on an assessment of proposals, set against those priorities, that was carried out in discussions with key stakeholders.

It is difficult to get the balance between adult services and child and adolescent services right, but that is something we are continually looking at. Making sure that we get that balance right is part of our NHS recovery plan ambitions, but it will require significant investment.

Stephanie Callaghan: During the committee's evidence session on perinatal mental health, we heard evidence from mums about the critical role that third sector organisations are performing locally. Their expertise is a lifeline as far as mums are concerned. In that evidence session, third sector stakeholders expressed concern about the fact that they are losing some of the local specialism and expertise that makes a really positive impact on the ground in local mental health services. How can more secure long-term funding be provided to support the delivery of mental health services by third sector organisations in community settings?

Humza Yousaf: It is really hard. I concur with everything that Stephanie Callaghan has said. As you would imagine, I see every day—from a local MSP's perspective, let alone from a health secretary's perspective—the value on the ground of the third sector organisations and partners that Ms Callaghan refers to.

As the Cabinet Secretary for Health and Social Care, I want to make it absolutely clear that we value third sector organisations not only through our words but through our deeds. Our 2022-23 mental health budget will increase by 6 per cent on the 2021-22 figure, and, this year, we have allocated a greater proportion to support community and third sector projects. That includes £15 million for grass-roots community groups via our communities mental health and wellbeing fund, to tackle the impact on adults of social isolation, loneliness and mental health inequalities.

On certainty for the future, I do not doubt that an ask that I get is one that every committee member gets, which is the ask for a multiyear budget. The Cabinet Secretary for Finance and the Economy has laid out some of the groundwork for how she might implement that for future years. That might provide a longer-term, sustainable funding outlook for third sector organisations in the future. We are not at that stage yet, but it is an ambition that the Government has.

The Convener: We will move on to alcohol and drug services.

Sue Webber: Earlier, I mentioned the Audit Scotland report that said that the Scottish Government needs to be more proactive in showing where and how the money has been spent in the budget in general. I am looking for support and commitment on that in relation to the importance that we are all giving to tackling drug-related deaths. Will the Scottish Government commit to publishing regular information that shows us the granular detail of how the money is being spent?

Humza Yousaf: In principle, I have no issues with that. I can look at what we publish at the moment, to see whether it would meet your expectations, and we can have a discussion about that.

In my letter to the committee, I referenced in some detail alcohol and drug partnership income and spending for 2021. We intend to publish the information once the analysis is complete. We will, of course, provide the committee with that publication. It will provide a level of detail on the income and spending of local alcohol and drug services, including what is provided in addition to Scottish Government funding.

If that does not provide you with the level of detail that you expect, I will be open to having a further conversation about how we can provide that.

Sue Webber: We are just looking to get a sense of the consistency across the country. That is a theme that we hear about at all committee meetings, because of the variances that happen.

In the budget, there is a £1.2 million increase in direct Scottish Government spending on the alcohol and drug policy. How does that relate to, and come together with, the commitment to an additional £50 million per year in this session of the Parliament? I am just trying to get a sense of what the relationship is. Perhaps Richard McCallum would be better placed to answer that question.

Humza Yousaf: I am more than happy to bring in Richard McCallum in a second, but, to be absolutely clear, that funding is in addition to the £61 million reducing drugs deaths budget, which includes the second tranche of £50 million of additional funding as part of the commitment for £250 million over five years from 2021-22. It is specifically aimed at supporting an additional response to our collective challenge on drug deaths.

The increase of £1.2 million in funding on alcohol and drugs for 2022-23, to which you referred, brings the total budget to £24.4 million. That includes investment in an alcohol harm and treatment policy team to deliver our alcohol priorities with Alcohol Focus Scotland, Scottish Health Action on Alcohol Problems and the Scottish Alcohol Counselling Consortium. It also provides funding for specific alcohol services that will be delivered to support the Simon Community Scotland to deliver a pilot managed alcohol programme.

That funding is in addition to the £61 million reducing drug deaths budget. I hope that that is clear. Richard McCallum might have something to add to that.

Richard McCallum: No, you have covered it. This is the second year of the £250 million over the session of Parliament, which is £50 million each year. It is covered in the 2022-23 budget.

Sue Webber: As I said earlier, every party in the Parliament is—[*Inaudible*.]—tackling this and we really want to ensure that that additional funding is breaking through and getting down to where it needs to be. How will the additional spending be targeted to ensure that it is used effectively? How will we measure that impact? What are we looking at to ensure that the money that we invest has the desired impact and that it saves lives?

Humza Yousaf: There is a slew of regularly published statistics—on which I know Ms Webber will keep a close eye, as we do—that will demonstrate whether we are making progress on that policy area, on which we all want progress to be made. Monitoring and evaluation will be at the heart of what we do. The Scottish Government works closely with our alcohol and drug partnerships to monitor the delivery of the national mission, which is what it is. Any organisation that receives funding for drug services will always provide regular reports on outcomes.

We will also work with public bodies that are vital in relation to that work, such as Public Health Scotland and Healthcare Improvement Scotland, to understand the bigger picture on delivery. Local interventions and the work at a local level will be really important, and officials monitor that, but we must keep an eye on the bigger picture. We will use that data to inform future funding decisions.

We will, quite rightly, be held to account on how we spend the money and on the difference that it is making. I expect that Ms Webber and all parliamentarians will ask questions to ensure that the Government uses the money in the most effective way possible, given the nature of the crisis that we are dealing with.

The Convener: Emma Harper has questions on sport and active living.

Emma Harper: I am pleased to be asking about sport and active living. We know that, during the first lockdown, people getting out for their daily mile or a walk was really important, including for

their mental health. There is a proposal in the budget that investment in sport and active living will double to £100 million by the end of the parliamentary session, which is really good news. How will the additional funding for sport and active living be prioritised?

Humza Yousaf: You are right to say that that is an important commitment. The issue has become even more important, given what we have been dealing with during the pandemic. We know that sport is good not just for physical health but for mental health, so it is important that we live up to the commitment to double our investment to £100 million a year by the end of this parliamentary session, which we intend to do.

How will the money be spent? It will allow us to rebuild capacity and resilience in the sector following closures during the pandemic. One cannot be unaware of the impact that the pandemic has had on sport. The impact has been felt at the local grass-roots level—for example, a daughter's football club that she goes to on a Saturday, which might have been hit hard by the pandemic but not have reserves to reach into—right through to the biggest clubs in the country. That has been the case not just in one sport but across myriad sports. Sport has been affected by the lack of people coming through turnstiles, for example. I will not pre-empt anything that the First Minister will say this afternoon, but omicron is clearly causing us great concern in that respect.

We work closely with sportscotland and other partners to understand how we can best increase investment in physical activity and sport while ensuring that we also address inequality. To be frank, I note that some sports have been better at dealing with inequality of access than others; other sports and sporting bodies have a little bit more work to do in that respect.

Emma Harper: I have a quick question about social prescribing. In the previous session, the Health and Sport Committee produced a report on the benefits of social prescribing and said that it is an investment, not a cost. Social prescribing is good for physical and mental health. What needs to be done, or is being done, to demonstrate that social prescribing is really good? How will that work provide evidence that social prescribing could benefit from further investment?

Humza Yousaf: I am a great believer in social prescribing, as is the Government. I can check the evidence and evaluation that we publish on social prescribing and provide Emma Harper with more information.

Our programme for government includes the commitment that, by 2026, every general practice will have access to a mental health and wellbeing service, and that there will be funding for 1,000 additional dedicated staff who will help to grow community mental health resilience and to direct social prescribing. I think that that will make a massive difference to access to social prescribing. I know from the community link worker in my constituency, who does an incredible job of reaching out to the third sector and other support organisations, that help with social prescribing has made a big difference to a number of my constituents.

12:15

I will look at what we have published or will publish on evaluating that and come back to the committee on it, via the convener. I agree entirely with the general point that Ms Harper made.

The Convener: Sandesh Gulhane has a quick supplementary.

Sandesh Gulhane: Kim Atkinson of the Scottish Sports Association said in her evidence to us,

"Given that culture is free, why is sport not free?"—[*Official Report, Health, Social Care and Sport Committee*, 30 November 2021; c 32.]

Do you accept that the cost of facilities can be a major barrier to participation? In hoping that you do accept that, I also ask what measures could be put in place to address it.

Humza Yousaf: Dr Gulhane is right about that and I absolutely accept that cost can be a barrier. That is why in my previous answer I said that some sports have done well at making their sport more accessible, but other sports and sporting bodies have some work to do.

In the 2022-23 budget, we have increased our funding for sports and funding to support Active Scotland's key outcomes of encouraging physical activity, developing physical confidence from an early age and so on. We are working very closely with sportscotland to make sure that it supports clubs in communities to offer a range of opportunities—for young people, in particular—to participate through community sport hubs. We are doing as much as we can to work through schools, as well.

Another example is that we are doing what we can to ensure that cycling is more accessible by providing bikes, where we can, to those who cannot afford them, and ensuring that they are available through community hubs, as well.

I will be happy to provide more detail, if I can. I agree with the premise absolutely; there are probably other areas that we need to fund. The cycling facilities fund is one example of what we have done. We also worked well with the Robertson Trust—which members will probably know—the Spirit of 2012 and sportscotland to

deliver the changing lives through sport and physical activity fund. That has provided direct resource to sport and community bodies to widen access. It directly funded 17 collaborative partnerships of sport and non-sport organisations to deliver sport and physical activity in communities, with a focus on accessibility. Dr Gulhane's wider point is one with which I entirely agree.

The Convener: Thank you, colleagues. I am sorry to curtail the sport questions, but we have only 10 minutes left and two members have not asked questions yet. We will move on to questions about health inequalities from Carol Mochan.

Carol Mochan (South Scotland) (Lab): Tackling inequality and poverty is, I believe, absolutely what we, as MSPs, are here to do. That goes for every portfolio. In almost every one of our evidence sessions we have heard from experts that in order to tackle health inequalities we have to tackle poverty. We have been advised that we have to be politically brave on the issue, so my question is this: are you prepared to be politically brave? Can you give us examples of what you believe we can do, and give us timeframes for that? It is very important that we know the timeframes within which we will measure outcomes.

Humza Yousaf: I agree entirely with Carol Mochan's assessment and her plea to every decision maker and policy maker that tackling poverty and inequality has to be the root of our mission in Scotland, because it touches on every portfolio in the Government. That is without a shadow of doubt.

I will not rehearse everything that I said previously about the good work that we are doing with the Deputy First Minister. However, to answer the question I say that the issue absolutely requires us to be politically brave and bold. We are up for that challenge. We have committed once again to doubling the child payment, which Scottish Labour had been calling for and has welcomed. There are a number of initiatives. Carol Mochan will know that we have committed to the family wellbeing fund for this session of Parliament. It is a significant investment that is designed to tackle child poverty.

There is no getting away from the fact that some of the investments will take the course of the parliamentary session to work. Of course, if we were able to meet our child poverty targets sooner, we would absolutely do that. Ms Mochan is probably aware of the detail of the child poverty targets, so I will not rehearse them. However, I give her the absolute commitment that regardless of whether we are in health, education, transport, housing or social justice, we are all absolutely at one on the drive to reduce child poverty. As the person who is responsible for the largest share of the Scottish budget by quite a distance, I am not unaware of my responsibilities in that respect.

Carol Mochan: We have heard evidence on the Scottish Government's place-based community-led approach. Will you give examples of where that will make a difference?

Humza Yousaf: Forgive me—I might have misheard. Did you ask about the place-based community-led approach?

Carol Mochan: Yes. It is referred to in our papers. Where could we use that approach quickly for people?

Humza Yousaf: I suspect that Ms Mochan and I are at one in our belief in the importance of the place-based community-led approach. We will bring together a range of work that is focused on supporting local-level action to improve health and wellbeing and to reduce health inequalities with the long-term preventative focus that we have spoken about. We want to support health and social care services to work as part of wider systems to co-create wellbeing locally. That will enable our health and social care providers to play their role as anchor institutions in community wealth building.

There are many good examples of that, such as the joint pilot programme that started earlier last year—the link up the Gallatown project, with Kirkcaldy YMCA and NHS Fife—in which people are provided with training and placement opportunities in a local hospital. Many of them have gone on to secure employment. I referred to the development at Parkhead, which is another good example and will be our single biggest investment in a health and social care centre. The centre will bring together community services that are currently located in, I think, nine other sites. I have spoken to a doctor at one of them who is part of the deep end project, which brings together 100 general practices in the most deprived areas, and she can absolutely see the value of the work that we want to do on that.

The Convener: Carol, can we move on?

Carol Mochan: I know that we are short of time, convener, but I hope that we can make a commitment to come back to the issue.

The Convener: Of course we will.

We have final questions from David Torrance on linking the budget to outcomes.

David Torrance (Kirkcaldy) (SNP): Good afternoon, cabinet secretary. The national performance framework has nine indicators and targets for health. How does that fit with other performance frameworks, such as the local delivery plan standards and the national health

and wellbeing outcomes? Which framework has the greatest prominence in setting budgets and spending decisions?

Humza Yousaf: I think that I caught just the end of that question. In essence, the outcomes in the national performance framework are a consistent thread that runs throughout our work. They inform our planning across the board.

I think that David Torrance asked about prominence and how spending decisions are influenced. In that regard, the national performance framework goes through everything that we think about. Every time we make a spending decision, we look at the outcomes in the national performance framework and other frameworks, including those that David Torrance mentioned. The national performance framework is our guiding framework for the whole of Government. As I said, it is a consistent thread that runs through all our work and informs our planning across the board.

David Torrance: Given all the information that is gathered and evidenced in the national performance framework, has it ever led to definite and specific changes in the budget plans?

Humza Yousaf: That is a good question. The national performance framework informs the budget. The impact on outcomes is, of course, considered when we make commitments. That, too, in turn informs our budget. We know that increasing health and care spending will directly contribute to the health and wellbeing of the nation.

The First Minister often talks about the fact that we cannot separate health and the economy—although people sometimes ask us to do so—because they are intrinsically linked. An increased workforce contributes to the economy, as does increased capital investment in health, which generates jobs and moves us towards our net zero goals. Our commitments to fair work and pay contribute to outcomes on poverty, and health has a role in each and every one of them.

The national performance framework sets our budget priorities. As I said in my previous answer, the framework is a consistent thread that runs through our entire consideration.

The Convener: That concludes our questions to the cabinet secretary on the budget. I thank Humza Yousaf and Richard McCallum for their time.

At our next meeting, which will be on 11 January, the committee will take evidence from stakeholders as part of our inquiry into the health and wellbeing of children and young people. We will also undertake scrutiny of the draft mesh removal reimbursement scheme that the Scottish Government provided in advance of stage 2 of the Transvaginal Mesh Removal (Cost Reimbursement) (Scotland) Bill at our previous meeting on 14 December.

As this is our last meeting of 2021, I take this opportunity to send my and the committee's good wishes to all our stakeholders who have helped us over the year. That concludes the public part of our meeting.

12:27

Meeting continued in private until 12:51.

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

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