OFFICIAL REPORT
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Health, Social Care and Sport Committee

Tuesday 20 September 2022

Session 6

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
26th Meeting 2022, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

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

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor David Bell (University of Stirling)
Leigh Johnston (Audit Scotland)
Professor Raphael Wittenberg (London School of Economics and Political Science)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 20 September 2022

[The Convener opened the meeting at 14:30]

Decision on Taking Business in Private

The Convener (Gillian Martin): Welcome to the 26th meeting in 2022 of the Health, Social Care and Sport Committee. I have received apologies from Evelyn Tweed. Gillian Mackay is joining us remotely and everyone else is here in person.

Under agenda item 1, do we agree to take item 4 in private?

Members *indicated agreement.*

Pre-budget Scrutiny 2023-24

14:30

The Convener: Agenda item 2 is evidence taking as part of the committee's pre-budget scrutiny for the 2023-24 budget. Witnesses are joining us both in person and remotely. In the room, we are joined by Professor David Bell, professor of economics at the University of Stirling. Thank you for coming along, David. We are also joined by Leigh Johnston, senior manager for performance, audit and best value at Audit Scotland, and Professor Raphael Wittenberg, associate professorial research fellow at the London School of Economics and Political Science. Good afternoon to you both.

This is a huge topic, so please forgive us for asking wide-ranging questions. We do not expect you to cover everything. There is tremendous pressure on the national health service not just in Scotland but in the whole of the United Kingdom, although we are concerned with the Scottish NHS, as a result of the cost of living crisis, the fuel costs that are involved in running large estates, demographic factors relating to staffing, increasing prescribing costs and various other issues. If the current plans for spending on the Scottish NHS look reasonable—notwithstanding the budget review at Westminster, which will have a knock-on effect in Scotland—can they be sustained in the face of all those pressures? I put that question to David Bell.

Professor David Bell (University of Stirling): Thank you for that wide-ranging question.

The question is what we can afford. We will always have resource constraints. Over the past 10 years, although the amount of spend has not increased substantially, health has had more protection than most of the other budgets. In my paper, I show that the UK as a whole spends about the average per head for the Organisation for Economic Co-operation and Development countries. However, that expenditure jumped much more than expenditure did in most other countries in relation to the pandemic.

In the UK, public expenditure statistical analysis shows that Scotland tends to spend more per head than England, although it does not spend nearly as much as Northern Ireland and it spends only slightly more than Wales. In the past few years, the gap between Scotland and England has been narrowing, and it is now quite small. A set of questions follows from those figures, if they are right. Have we noticed that waiting times for hospital and doctor appointments have got significantly worse in comparison to England? I am not clear that that is true. It seems that spending in

England has grown quite a lot, and a little bit faster than spending in Scotland in recent years, but the outcomes are nevertheless worse in some ways—I am sure that Raphael Wittenberg can talk about social care—than those in Scotland.

If we look ahead, the health and social care budget will be the largest in the Scottish Government's portfolio. It used to be slightly smaller than the local government budget, but over the past 10 years that has turned around. However, its projected growth is not necessarily as big as that of some of the other important portfolios in which more than £1 billion is spent.

A big change is coming, as you can see from the spend figures through to 2022-23. That is because the national care service will be established and a big tranche of extra money will go to the health budget. How that will be split between local government, which is primarily responsible for social care spend at the moment, and health spend is not entirely clear.

I will add one other point. Much has been made of preventative spend in quite a lot of the evidence that the committee has received previously, but it is not clear that such spend has achieved what was hoped of it in relation to the Christie commission. There is also a question about whether the amount of resource that has been allocated to preventative spend has been sufficient to make a difference. A key Scottish Government objective is to raise activity levels, but whether that is being achieved with the resource that has been allocated to that end is a question on which we need better data.

There are lots of pressures on the health budget. In demographic terms, because the population is ageing, we need to increase the budget year on year. However, resources are limited and there are other calls on the Government's budget. Limitations arise from how quickly the economy is growing and, therefore, how quickly tax receipts are rising. That is another consideration that must be borne in mind when you are looking ahead. How much it will be possible to allocate to our NHS bodies, be they territorial boards or national boards, depends very much on the health of the economy, as well as on the division of the total resources in the Government's portfolio.

The Convener: I remind colleagues who are joining us online to use the chat function to let me know when they want to comment or add to anything that has been said. As no one wants to do that at the moment, I will ask David Bell a supplementary question.

I will not go too deeply into preventative spend, as colleagues will ask about that during the meeting, but we need to quantify where other interventions and areas of spend in portfolios have impacts on health. If we were to take money away from an education budget in order to put it towards health, that could have the impact of increasing people's ill health. If we put more money towards, for example, net zero, that will have an impact on health as well. You mentioned data. Are we almost too fixated on the health budget being about health, rather than having a general budget that impacts on the nation's health? It is also very difficult to quantify that.

Professor Bell: It is extremely difficult to quantify that. This morning, I was involved in a conversation at the University of Edinburgh about the effect that climate change will have on health and what action might be taken to alleviate that. Before we can take action, however, we need to have clear evidence on that. That has been, to a certain extent, part of the problem associated with short-term budgets. A lot of the evidence that the committee has taken has criticised the fact that boards can look ahead only for a year, which does not create a situation that supports the long-term collection of data.

Let us consider interventions in education. Last weekend, I was involved in a discussion in Helsinki with experts in dementia, who were considering whether education is protective against dementia. To understand that, we must have some idea of people's life histories, in a sense. Dementia is almost unknown before the age of 65, so looking back to someone's education means going back a long time before.

There must be willingness to approach data systematically. I am sure that Raphael Wittenberg knows about the difficulties in getting good data, particularly in social care. That is a big problem because the sector is diverse—it is much more so than the NHS, in some ways. There is quite a lot of effort on data, but the question is whether it addresses the needs for dealing with the issues that you raised, which are about the kinds of spend on housing, education and so on, and the effect that that has on people's health.

The Convener: That comes back to the issue of short-term spending and short-term outcomes, which quite a lot of people have brought up in their written evidence. Things such as waiting times can be quantified on a quarterly basis, but the health outcomes are more difficult to assess.

Professor Bell: The trouble is that there is a tendency to measure what we can measure, which is not necessarily the right thing to measure. Waiting times are possibly an example of that.

The Convener: Do our other witnesses want to answer some of the broad questions that I put out there to kick us off? Data has been mentioned,

and I know that Leigh Johnston lives and breathes data.

Leigh Johnston (Audit Scotland): I will raise a few things. We have been clear that, despite the planned budget increases that were set out in the resource spending review, health and social care faces an uncertain and challenging financial position over the next four years and beyond. We said clearly in our report "NHS in Scotland 2021" that

"The NHS was not financially sustainable"

even

"before the ... pandemic, with boards relying on additional financial support from government"

and lots of non-recurring savings. The pandemic has exacerbated the scale of the financial challenge.

NHS boards have been fully funded over the past two years to meet their unachieved savings, but that is stopping in 2022-23, when boards will be expected to make their planned savings without additional support from the Scottish Government. That will be very challenging given all the pressures that have been outlined, such as pay costs, inflation and energy costs, as well as on-going operational costs, which have already been an issue.

We know that boards have submitted three-year financial plans to the Scottish Government, which are important. We have not had a chance to look at them yet, but the hope is that they will start to give us a better idea of the forward-looking financial position for NHS boards.

You talked about outcomes, convener. We have been clear about the impact that the pandemic has had on inequalities of health, wealth and education. It has had a profound negative impact on physical and mental health. It will also have had an impact on the outcomes that are set out in the national performance framework. That requires a cross-Government and cross-public sector response—including the third sector—to try to deal with the inequalities that are so deeply embedded in Scotland and improve our outcomes. As we have already discussed, that includes a focus on preventative spend, although we know that that has been very challenging.

14:45

On outcomes, as has been said, it is very difficult to know what is being achieved because of the lack of data in certain areas in health and social care. In particular, short-term measures, throughput and output are focused on, rather than outcomes. There is a need to move towards looking at what outcomes are being achieved through the money that we are spending. A number of our studies—for example, our "Children and young people's mental health" study in 2018—have found that we could not track the spending or tell what difference any of it was making because the outcomes were simply not being measured. That is repeated across health and social care.

Professor Raphael Wittenberg (London School of Economics and Political Science): As David Bell indicated, I work mainly on social care, and my research has been mainly on England, but I think that the general points would apply equally to Scotland.

I will make three points, if that is okay. First, the sociodemographic pressures are rather greater on social care than they are on healthcare. For example, as members know, the fastest-growing numbers among older people are those aged 85-plus. A high proportion of those in care homes—about 70 per cent—have dementia, and the average age of the onset of dementia is around 83 or 84. The pressure on social care for older people is considerable because of its concentration on people aged 80-plus and 85-plus.

For the younger age group, there have been—and it is projected that there will continue to be—large increases in the numbers of people with learning disabilities, including moderate to severe learning disabilities, for which social care may be required. We are updating work that was done by Lancaster University on that. We have not finished that, but we are getting very similar findings. From looking at the numbers expected to turn 18 over the coming decades and beyond, potentially, there will be substantial increases in demand for learning disability services.

Secondly, in looking forward, for older people a lot will depend on what will happen to disability rates, whether those rates will fall or rise, and whether there will be a compression or expansion of morbidity and disability. We have done quite a bit of work with colleagues in Newcastle on that. I think that we would be expected to say that the jury is out and that there are different views but, over time, that will make a considerable difference to what happens to disability rates in later life. The link with prevention has already been raised.

My third point is about the rise in pay rates in the social care sector. As members know, a high proportion of social care staff—carers in home care and residential care homes—are paid at or not much above the national living wage. In our work and projections, we take account of the increases that the Government has announced up to 2024. Obviously, having a low-wage sector will also make a big difference for the coming few years. We assume that, beyond that, wages in the care sector will rise in line with the wider projections for the economy by the Office for

Budget Responsibility. However, given the shortages of staff, they might be too low. Wages might have to rise more quickly in the care sector than in the wider economy in order to ensure that we can recruit and retain sufficient staff with the skills and aptitude to work in that sector.

Those are three points that I particularly wanted to highlight.

The Convener: I thank all the witnesses. Everything that they have said is a real springboard for deeper questions from my colleagues, who want to pick up on quite a few things that have been mentioned.

Tess White (North East Scotland) (Con): I declare that I am a fellow of the Chartered Institute of Personnel and Development. I always look at things through that lens before thinking about politics.

My question is for Professor Bell first. I have two points. There is a 0.6 per cent planned increase in NHS spending. There are huge pressures on the NHS, but we are talking about a small increase. We have statistics that show that only 63.5 per cent of patients are being seen within four hours. That is the lowest percentage ever recorded. You made the point that it is not possible to deliver any form of workforce plan if there is very short-term planning of not more than a year. I know that you have looked at labour economics. The issue seems to be more than money: there is an inability to plan the workforce.

Professor Bell: It seems to me that workforce planning is an essential component of any long-term vision for the NHS. That must be predicated on making work in the health service or, as Raphael Wittenberg said, in social care an attractive option. The wages of public sector staff in general, including those of NHS staff, have been falling relative to those of workers in the private sector over the past few years. Unsurprisingly, as a result of that, it becomes more difficult to recruit.

Raphael Wittenberg made a point that touches on your question and is worth bringing up. Although those who supported Brexit perhaps intended that overall levels of migration to the UK would be reduced, that has not, in fact, been the case. Net migration to the UK—a huge proportion of which goes into health and social care—has stayed pretty much the same, although the locations that people come from have changed. For example, whereas we might have had lots of people coming from eastern Europe before Brexit, they now come from India, Nigeria and other countries. That is how things have panned out.

Whether it is sustainable in the long run to rely to a large extent on migrant labour to be part of the workforce is a reasonable question, but that reflects the fact that it is difficult to recruit UK-born or Scotland-born people into health and social care. The reliance on migrant workers has not really changed; if anything, it has increased.

Tess White: I have a follow-up question. We can look backwards, but I want to look forwards. What levers can we pull to change the situation?

Professor Bell: It seems to me that we must think very carefully about training. Those are all professional jobs. How can we make training more accessible and less expensive? That seems to be the most obvious route.

There is also a recall route. People have left. During the pandemic, part of the problem came from understandably high numbers of people withdrawing from the NHS. Thought has to be given to how to find incentives to bring them back in.

The Convener: I do not know whether any of our colleagues who are online want to add anything in response to Tess White's questions. If so, I can come back to them.

Sandesh Gulhane wants to ask a question, as well. Please direct it to whoever you want to answer it.

Sandesh Gulhane (Glasgow) (Con): I want to ask Leigh Johnston a follow-up question. You talked about data and how you are struggling to find information. My question has two parts. Would you like outcomes to be explicitly stated when spending in the NHS is announced? If not—or on top of that—what can we do to improve data so that we can see what the outcomes are? Let us be honest: outcomes are the most important thing.

Leigh Johnston: I would not like to comment on whether outcomes should be stated when funding is announced. We would like to be able to track the funding to see where it is being spent and then know how the outcomes of the different service areas are being looked at.

I gave the example of "Children and young people's mental health". We could not track where the spending was going, and very little work was done on what difference any of the services that were being delivered was making to those children and young people. As another example, health and wellbeing outcomes formed part of our integration report in 2018, but they are not reported at the national level. Individual integration joint boards talk about those outcomes in their annual performance reports, but they do so alongside a lot of indicators that do not actually tell us a lot about the outcomes.

The public sector is about improving outcomes, and it is very important that we can track the spending and understand what difference it is making.

Sandesh Gulhane: Forgive me—as you said, you cannot track the spending, but what would you like to see happen? How can we track that spending? My question was about what difference we can make to make it easier for you.

Leigh Johnston: As we have commented lots of times, a range of data is not available. We know very little about activity and demand in general practitioner practices, for example. Public Health Scotland is working on that, but how can we plan and scrutinise or make decisions when we do not have solid data to base that on? As the other witnesses have said, there is very little data on community care and social care. Even our workforce data is not as robust and reliable as it could be.

The Scottish Government has published its health and social care workforce strategy, and it has made lots of commitments around improving the data that is available to help to plan our workforce. However, it promised that in the 2018 workforce plan, and we have seen very little progress. It is the same with the GP data. Over the years, there have been lots of commitments to improve that situation, but progress has been slow.

It is about improving the availability of data so that we can begin to look at what is being achieved, what impact things are having, and the difference that the money that the Government is spending is making to people.

Professor Bell: I will add to that answer. Having the data is one thing, but you also have to be able to process it and make it accessible. There are lots of ethical problems around that but, if the data is made accessible in an anonymised way, lots of people can look at it and try to come to conclusions about how efficiently the service is run.

Emma Harper (South Scotland) (SNP): On the back of Tess White's question for Professor Bell—I will be quick—I have a question about recruitment and retention, and the plans for clinical training and career pathways for health and social care workers. The Scottish Government has introduced bursaries for training of nurses, midwives and paramedics, and there is free university tuition in Scotland. I think that that will help recruitment, as well. Should anything else be done or introduced, in addition to the bursaries that have been introduced already, to support further recruitment and retention, and to encourage some of the people who have left the healthcare environment to return?

15:00

Professor Bell: You mentioned the sorts of measures that are needed to get people started off in the various professions. We then need to understand why people leave. The pandemic was a very special time when staff were under huge pressure, and that pressure has not completely or even partly been alleviated yet, because of some of the knock-on effects of the pandemic. There is a clear need to understand why people leave and whether what is needed to bring people back is financial incentives or something about work practices. Is it about flexibility, shift patterns or, potentially, childcare? I do not have the answer at the moment, but we need to be clear about why we have had that leakage from the system.

Emma Harper: Thank you.

The Convener: Before I move on, I will check in with Professor Wittenberg. You have not said that you want to come in, professor, but social care has been mentioned, and it has particular relevance to Emma Harper's question about staff. You mentioned issues around staffing. Do you have anything to add on that?

Professor Wittenberg: I am happy to do that.

There are two big differences between the social care and healthcare workforces. One is that a high proportion of the social care workforce are not professionals—they do not need degree-level qualifications as is the case in nursing, let alone medicine. In the labour force, there is competition between the social care providers, the retail sector and the hospitality sector—it is a very different type of workforce.

Secondly, unlike in healthcare, the employers in social care are mainly not in the public sector; they are mainly in the private for-profit sector and the charitable sector, and therefore they are at one remove from the commissioners of the services, which are statutory bodies—IJBs in Scotland and local authorities in England. That creates a very different situation.

Linked to that, there is a lack of career progression for care workers who work in care homes or in the home care sector. Work that we have done using labour force surveys suggests that people leaving the care sector who are carers, rather than professionals, are moving on to the health service or sometimes other parts of local government. There might be a sort of informal career progression of people moving from social care into the NHS, perhaps as healthcare assistants and ultimately into training. However, one of the big issues is not just pay; it is career progression and career prospects in the social care sector.

The Convener: That prompts me to ask another question—I am sorry to butt in before handing over to my colleagues. One objective of the establishment of a national care service is to have

that structured career progression. Could that make a difference in that respect?

Professor Wittenberg: I am not sure. I am not aware of evidence on how much difference it will make. As I understand it, the reforms have not happened yet, so I suppose one would have to look at other countries. I am sorry, but I do not know what messages we get from other countries.

The Convener: Thank you—I put you on the spot there.

Paul O'Kane (West Scotland) (Lab): Good afternoon to our witnesses. I am keen to build on some of what we heard about financial sustainability in the first part of the meeting. From reading some of the work that Audit Scotland has done, it strikes me that there is a requirement for innovation in order to achieve financial sustainability. Of course, progress on that is hampered by the fact that the NHS faced serious financial challenges before the pandemic and those were exacerbated by the pandemic. To what extent do you feel that enough is being done to try to achieve transformation in the NHS in order to lead to financial sustainability?

I put that question to Professor Bell first. We could then hear from Audit Scotland.

Professor Bell: That is not my expert topic. Over the past two years or so, it has really just been about keeping the head above water. Understandably, it has been pretty difficult to think about innovation over that period.

It would be good to think that we now have an opportunity to innovate more. We have to think about where that innovation might stem from. To what extent do individual health boards have the freedom to innovate relative to innovations being determined from the centre and rolled out? What the most effective way to approach that is is a reasonable question. Should we be encouraging NHS boards to look into changing their practices when they might worry about being singled out when things go wrong? One cannot expect every innovation to result in a successful outcome. Perhaps we should be prepared to allow for something not to work. I understand that that is difficult, but to some extent it is something that we just have to live with.

Paul O'Kane: The point about the level of local innovation is well made. However, there are some national innovations that we have been waiting for for some time, such as the single patient record, new technology and digital health. Is it your sense that a lot of that has to be driven from the centre across all health boards in order to make that difference?

Professor Bell: I guess so. You will get a differential response across the boards because they vary so much in size, and the capacities to adopt new practices are inevitably partly determined by the size of the boards. The bigger boards will have extra leeway—there is the economies of scale argument—to move forward with innovations, whereas the smaller ones will not have that freedom.

Paul O'Kane: Does Leigh Johnston want to comment on that? My question is partly based on Audit Scotland's analysis that identified the need for that innovation to be sustainable as well as the difficulties of standing still.

Leigh Johnston: As we said, we saw some innovation during the pandemic, particularly in some of the digital advances, such as NHS Near Me and the increase in non-face-to-face consultations. The recovery plan also sets out several new ways of delivering services and different patient pathways, such as the national treatment centres trying to divert patients away from acute hospitals to increase in-patient and day-case activity. We must not lose the innovation and progress that took place during the pandemic, and we must try to advance it.

The Scottish Government has also set up the centre for sustainable development, which is trying to share some of the new practice and different ways of doing things across the boards in Scotland. It is important that we hold on to that.

However, there are lots of risks in relation to recovery and redesign. I have already touched on workforce availability, which is one of the major risks. Another thing that the Scottish Government is looking at is how we might use staff differently. That work is to be developed further.

In "NHS in Scotland 2021", we outlined several risks around innovation. It is important that we think about and through those. As part of our next NHS in Scotland report, we will look in depth at the backlog of patients and the deliverability of the recovery plan, the progress that has been made, and the innovations that are outlined in that. That is due for release in February 2023.

Paul O'Kane: Another interesting point that Audit Scotland made in its report was about leadership and stability in leadership. It highlighted

"a lack of stable senior leadership, with high turnover and short-term tenure",

particularly in relation to directors of finance. To what extent is the lack of the right sort of leadership related to the inability to achieve long-term sustainability?

Leigh Johnston: There has been less turnover in the past year, so it is fair to say that the leadership has stabilised slightly, but there has been a high turnover of senior leadership. Our concern is about the long-term vision of

transformation. For example, the ambition of integrated health and social care services requires collaborative leadership. That integration is based on relationships and building up trust between different partners in order to really progress and advance the innovations, ideas and new ways of doing things. Of course, high turnover at senior leadership level makes that very difficult to achieve.

The other issue is that our leaders have been under extreme pressure throughout the pandemic, and now they have recovery and redesign to deal with, as well as the development of the national care service. It will be very challenging for them to manage all that and to do it well.

The Convener: Emma Harper has a supplementary question.

Emma Harper: I picked up from Dr Bell's submission that a review is being undertaken of the NHS Scotland resource allocation committee—NRAC—formula and that certain recommendations have been asked for in relation to the way in which funding is allocated. I am thinking about remote and rural areas, whether those are in the Highlands and Islands or in the south of Scotland. What, if anything, needs to be changed in the NRAC formula?

Professor Bell: Basically, the NRAC formula works to allocate money to territorial boards, which is mainly for hospitalisation and GP prescribing. That is driven primarily by population, then by the age-sex structure, and then by various indicators of morbidity and mortality. I do not want to prejudge where that might go in future, but a lot of our discussion today is relevant, because, in effect, it is largely about the conditions of demand for health services and how that might be higher in areas where, for example, there are lots of older people.

We might need to do some more work on how easy or difficult it is to attract workforce to different areas. Not all of Scotland is equally attractive to healthcare professionals, and some areas have considerable difficulty in recruitment. That goes back to the overall workforce set of issues. Off the cuff, I am suggesting something that might be thought of in relation to the formula in future, but I am sure that more thought has to go into it.

Emma Harper: Okay—thank you.

The Convener: We move to the topic of Covid-19 recovery, although we have been skirting around it for the past three quarters of an hour.

David Torrance (Kirkcaldy) (SNP): Good afternoon. The budgets in 2020-21 and 2021-22 had large additional sums for health and social care. Is there a need for continued Covid-19-related spending allocations for health boards?

15:15

Professor Bell: As usual, there is no easy answer to that question. The question is about how Covid has changed working practices. In some senses, it has made things more efficient: we have heard about how GP practices are using online appointments. Precautions must still be taken, which adds to costs. Long Covid is still an issue that may also add to costs.

In relation to what Raphael Wittenberg said, one issue that has emerged in the UK in particular is that we are seeing a lot of workforce pressure in all kinds of sectors, with hospitality perhaps being the most prominent one. One reason for that is that about half a million people have left the workforce, many of whom have said that they are disabled. Those people were previously working but now say that they have some kind of problem. It is now more common for mental health to be signalled as a possible cause of people leaving the workforce. That will add to the pressures on the NHS. I am not giving you a definitive answer, but it seems to me that there are many pressures that are going in different directions.

There is also the question of what your objective is. Do you want to return to what might be described as "normal" levels? Those might be 2019 levels, but, as we have already heard, the NHS was struggling to keep its head above water even then.

That is an incomplete answer, but it touches on some of the most relevant issues.

Leigh Johnston: I want to add that I think that on-going costs will be caused by Covid-19 in 2022-23. There are increased infection prevention and control measures, among many other things. It is our understanding that NHS boards have been given an individual funding envelope to cover their Covid-19 costs in 2022-23, but that there is an expectation that they will now begin to manage those down.

David Torrance: New working practices were brought in because of the Covid pandemic. How do we go about redesigning services? Will there be savings, especially from digital work, community care or care at home? The most important thing is to get the public to buy into all that. You mentioned GP practices. Everyone at this table knows that one of the top complaints that we hear is about the lack of face-to-face contact with GPs.

Professor Bell: It is important to take the public with you. If the public are not happy with the service that they think they are getting, you can innovate all you like but it will not satisfy them. You want to have the best healthcare that you can facilitate, but that can happen only if the public are happy with the way in which it is being delivered.

Otherwise, you will end up with what we might describe as unmet need. People will not go to the proper diagnostic services and they will end up with problems that are difficult to deal with.

If you are changing practices or are going to use more individualised data, you must use whatever works best to bring the public along with you and to get them to form an overall view that that is the best way to proceed.

Professor Wittenberg: In the unit where I work at LSE, we are doing research on a number of the topics that have been discussed in the past few minutes, including innovation in adult social care, Covid and long Covid. Of course, we do not yet have the results of that research, but as findings emerge, we would be delighted to make those available in Scotland, as in England.

On long Covid, we are looking at work with NHS England in respect of registries of data. We are also just starting a project to look at the impact of long Covid and Covid on the demand for adult social care. That reminds me to raise the issue of unpaid carers—mainly family and close family members—who provide the great majority of long-term care. One of the issues that I think we should be looking at in the study that we are starting is the potential impact of long Covid on unpaid care, in respect of carers who may no longer be able to care so easily, as well as people who need care from their families or others and whose condition may be more complex if they have long Covid alongside other conditions. We are looking at some of the topics that have been under discussion, and I hope that we will have emerging findings over the next year or two.

The Convener: David Torrance has one more question, after which I will bring in Carol Mochan.

David Torrance: My question is for Audit Scotland. Are our management boards and senior managers making the best use of data to recover from Covid-19, or are there big gaps that stop them doing that?

Leigh Johnston: All that I can comment on is the fact that we have been very explicit about the gaps in the data that is available, which leads you to question how decisions are being made and how performance is being scrutinised.

As I have said, we know very little about GP demand and activity, we do not have a good understanding of what is going on in the community, and some of our workforce and social care data is not as robust and reliable as it could be—we have commented on the lack of social care data many times.

I am sure that, locally, health boards in different areas are collecting their own information; however, we look at national data. Evidently, the national data is not available. Sometimes, I would question whether there is sufficient data for planning to be done and for good decisions to be made.

The Convener: We go to Carol Mochan.

Carol Mochan (South Scotland) (Lab): I have a quick question for Leigh Johnston. Recently, it has been mentioned to me that one of our responses to Covid in hospitals was to increase bed capacity—which is understandable—and that that has continued. Some health boards are concerned that the staffing issues were never addressed. There are staffing issues to do with recruitment, and the full-time equivalent posts are simply not there. It was mentioned to me that staffing was running at around 70 per cent of the funding allocation. Is that something that you have picked up on across the board?

Leigh Johnston: We have not looked at that in any detail. The only thing that I will comment on is that we know that there have been huge staff absences and that there has been a significant increase in the use of agency and locum staff. That does not really answer your question, but the huge increase in agency and locum costs shows the pressure that boards are under to have sufficient staff in place in order to meet the needs of their different services.

Carol Mochan: If I wanted to look at bed capacity before and after Covid, where would be the best place to look at that information and the staffing levels around that?

Leigh Johnston: I think that you would need to look in a mixture of places. Public Health Scotland would deal with bed capacity, and NHS Education for Scotland is now responsible for staffing data. That is where you would be able to access that information.

Carol Mochan: That is helpful. Thank you very much.

The Convener: Emma Harper wants to pick up on something that Leigh Johnston said.

Emma Harper: Yes. Thank you, convener. I am sorry to keep coming in.

Leigh Johnston mentioned that data or other information was missing from general practices. Why is that? Is there a plan to get that data? Is that in process, as Audit Scotland has highlighted that that data is missing?

Leigh Johnston: We know that Public Health Scotland is working on trying to improve the situation, and I think that it is due to publish some data in the springtime next year. That will be fairly high-level data. I think that we have told the committee before that work has been done on other areas in relation to the Scottish primary care

information resource, or SPIRE, system in GP practices. Whether practices have adopted that has been patchy so, again, the data will be patchy.

However, I think that Professor Bell mentioned that there are issues relating to data protection and ethics. Applications can be made to get some data about different specialties or condition-specific data, but a long process has to be gone through. Our point is that there is no nationally available data to give us a good insight into activity and demand in GP practices. However, as I have said, Public Health Scotland is, as far as we are aware, working on that, and it is due to publish data early to mid next year.

The Convener: We move on to questions on health and social care pay.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): I thank everyone for coming to the meeting.

We have already touched on pay quite a lot. Since the end of 2019, there has been a significant increase in employment in NHS Scotland. We are looking at a figure of 14,000 and, quite rightly, we are not expecting that to drop off to pre-pandemic levels. There are two really big demands across health and social care: the demand to increase pay, especially with high inflation and the expectation that it will rise further, and the demand for additional staff. How can those two things be balanced? I ask Professor Bell that question first.

Professor Bell: If you want to increase the complement of different professions in the NHS, you have to consider the set of issues that attract people to work in it. That will include pay, of course, and it will also include conditions, which is a wide set of topics. It is clear that you will want people to be comfortable in the profession.

Pay matters—it matters relative to what people's alternative is. That is most obvious in social care, as Raphael Wittenberg has said, because the alternative is often retail or hospitality, for example. The training requirements are not as high as they are in the NHS professions. Nevertheless, people can withdraw and even look for other careers.

If there is a desire to increase the overall complement, it must be established that there is a need to do so. I guess that if you were being successful with your prevention strategies, you might not need to think about such a large increase, but if you want to maintain that higher establishment, you cannot ignore pay.

15:30

It is always about the next best alternative. It looks to me as though real pay for most people will fall this year, in the sense that the rate of inflation will exceed the feasible increase in nominal salaries. People may want to go for the least worst of those options.

If there is increasing disenchantment with the real levels of pay that people are getting, that means almost redoubling the effort to make sure that conditions are suitable and that, even given the cost of living fall, working in the NHS is still sufficiently attractive to keep people in it.

Professor Wittenberg: The Institute for Fiscal Studies has done some research on the link between nurses' pay and the supply of nurses. I do not have the findings in front of me, but I am very happy to send the clerks a reference for that, if it would be helpful.

Stephanie Callaghan: It would be incredibly helpful to have that.

Professor Bell, you have picked up on a point about the difference that prevention strategies could make. Would you expect preventative care and preventative strategies to make quite an impact going forward? Are there concerns around service delivery, if pay is taking up quite a chunk? Might service delivery be affected if there is less funding?

Professor Bell: It is always a trade-off. It seems to me that preventative strategies have suffered, in relative terms, because it is so difficult to establish how effective they are. I was in Finland three days ago and learned that Finnish schools close for a number of days each year, and all of the children go out to ski. We have the daily mile in Scotland to get activity levels up. The Minister for Public Health, Women's Health and Sport, Maree Todd, is very keen on increasing activity levels. Increased activity is one part of it. Reducing smoking and alcohol consumption are also parts of it, but it is difficult to show what the difference is, because the difference will come years later.

We know that Scotland's healthy life expectancy is low compared with European countries. What we are spending on the NHS is not making the same difference; we are spending about the same, but in those overall terms, the outcomes are certainly not that good.

Again, it is the difficulty of short-term budgeting in putting in place long-term strategies. I was speaking to someone about that this morning. I am very glad that the daily mile, which was a Scottish invention, seems to be pretty much established, but it is extremely difficult to sell such strategies at the sharp end, when there are real problems about healthcare delivery systems through the NHS and the social care system.

Stephanie Callaghan: It would be good if Professor Wittenberg could comment.

Professor Wittenberg: I am not sure that I quite caught the question. Was it about preventative measures?

Stephanie Callaghan: Yes, it was about the protective impact of preventative measures, but I also asked about service delivery—for example, about concerns over whether there are increasing demands on staff pay and therefore less money to be spent on service delivery, and how that might be tackled.

Professor Wittenberg: Unfortunately, in the field of social care, the evidence on preventing the onset or worsening of disability is rather limited. We did some work with colleagues in other European countries. Only in very particular areas, such as the prevention of falls, is there firm evidence. One of the challenges is a lack of evidence on preventing disability in later life. As David Bell has indicated, it would not be easy to generate such evidence, because of the time lags between the intervention and the desired outcome.

We have worked with colleagues, and plan to do more, on the prevention of dementia. In that field, there is a shortage of information among the public that Alzheimer's dementia, in part—at least a third of it—is preventable, through the reduction of various risk factors. Arguably, those have already been mentioned. They relate to smoking, to physical activity, and to controlling blood pressure, for example in middle age—which we have shown is cost-effective even if one looks only at the dementia outcome. Others may be less well known, such as the use of hearing aids. There is evidence that hearing loss, if it is not corrected using hearing aids, is a risk factor for dementia.

There may be some new fields in which interventions could be helpful. However, as David Bell has indicated, getting the evidence is part of the challenge.

The Convener: We move on to discussing the national care service, the bill for which we are about to scrutinise at stage 1 in the coming months. I hand over to Sandesh Gulhane.

Sandesh Gulhane: I might email you on that last comment about hearing aids, because I had never heard of that before.

However, moving on to the theme of the national care service, a lot of the responses to the call for evidence deal with the financial memorandum, which was presented just before the summer recess. For example, the West Lothian integration joint board said:

> "there is so little detail provided in the Financial Memorandum as to the basis of the costs, it is impossible to say if the costs included are reasonable and accurate."

David Bell, do you share those concerns?

Professor Bell: To a certain extent, I do. I have not been closely involved. I spoke to Derek Feeley during his inquiry, but I have not been closely concerned with the implementation. I have to say that I am not clear on exactly how the additional money is to be allocated.

Adding extra money to the NHS is reasonably straightforward. Adding it to the care service, as Raphael Wittenberg has said, involves a complex sector of voluntary and private providers and unpaid carers—a host of actors. How to provide additional resource, and what that means at the national level, seems to me to be a big challenge.

Raphael mentioned the possibility of having a better career structure for carers. If that was part of the new care service, it would be a plus. However, there are a lot of unknowns about how that might affect local delivery. I am therefore reserving judgment, at the moment, to see how it further develops.

Sandesh Gulhane: I wonder whether Leigh Johnston might have a thought on that as well.

Leigh Johnston: Again, we have submitted a response to the consultation on the bill. Given that the details of the arrangements have yet to be determined and finalised, the scale of the costs involved in the financial memorandum is an estimate, with a lot of caveats. The affordability of the vision that is set out is not certain, given that the actual scale of the costs is not yet clear.

Sandesh Gulhane: Local authorities and other stakeholders are also very concerned about the administrative and structural costs of establishing a national care service. Do you share their concerns that a high administrative cost will lead to less financial resource for service delivery?

Professor Bell: Clearly, some sort of administrative overhead will be associated with the national care service. We have seen similar things in relation to Social Security Scotland, for example.

I am unclear at the moment as to what that might mean and what the trade-off might be between additional efficiency savings at the local level compared with the administrative costs at the national level. I really do not feel that I can comment on that, because it is not clear what the size of the administrative overhead will be or how efficiencies might be gained at the local level—given, as I have said, that it is a much more diverse sector than the NHS.

Sandesh Gulhane: You are saying that you are unclear about it—what can we do to make that data available to make it clearer as to what is happening?

Professor Bell: It is partly about where local authorities will stand in relation to the provision of

care services. There is clearly a potential gain through improved interaction with the health service and fewer delayed discharges.

As far as delayed discharges were concerned, we seemed to be getting to a good place around 2018 or thereabouts. However, with the difficulties that the pandemic caused in the care home service, those successes have, to some extent, been wiped out.

All that I am doing is conveying uncertainty here. It will be important for the committee to understand more clearly than I think is possible at the moment exactly how the implementation will happen, what the administrative costs will be, how it will affect local authorities—and the interaction between local authorities and the NHS, and the interaction with all the separate providers—and whether we largely adopt the same charging structure as the one in England, with slight, but not massive, variations around when someone becomes self-funding in social care, for example. Also, will there be changes to those asset-based tests on whether people become self-funding?

The Convener: We move on to the NHS estate and its sustainability. Emma Harper is leading on this theme.

Emma Harper: Since we got our papers last week, I have been doing a bit of reading about the NHS estate and sustainability, and how the NHS can achieve net zero by 2040.

I am interested in what the panel thinks about 20 million miles per annum being saved during the pandemic through the implementation of NHS Near Me. That shows that mileage reduction can be achieved—it is a hefty figure. When calculated as CO_2 emissions saved, it is in the billions of milligrams.

15:45

Another issue relates to remote virtual clinics and using telemedicine so that, for example, blood pressure readings can be obtained remotely and then analysed by a GP, who can see the results without seeing the patient.

How do we marry up the technologies? How do we get the biggest bang for our buck in saving emissions in our NHS estate? I will go to Professor Bell first, as he is in front of me.

Professor Bell: That is not my specialist subject.

There have been many innovations that have moved in the right direction. The use of drones for delivering medicines is another one that has been explored. However, much of the estate is not efficient in its annual usage of CO_2. Transport is important, but the issue is the physical buildings and the level of investment that is needed to convert them to being more sustainable. For some—hospitals, for example—that will be a big challenge. Progress can be made only if investments are made and the learning is shared across different parts of the NHS, and willingness to do those things is important.

The Convener: Would either of our remote witnesses like to come in on that question? Leigh Johnston, I saw you nodding along as David Bell spoke. Would you like to come in?

Leigh Johnston: I agree with Professor Bell, but it is not an area in which Audit Scotland has done a huge amount of work. We identified the net zero requirements as adding a challenge to the NHS recovery process. Achieving them will require additional investment in the already pressured budget. The one thing that we agree on is that it is vital that the NHS makes the most of the opportunities that have arisen during the pandemic to reduce carbon emissions through the things that Professor Bell talked about and through NHS Near Me. Not only reduced travel but reducing the use of personal protective equipment, for example, will contribute towards achieving those targets.

Climate change is in our future work programme. We will do more work in the area but we just have not done an extensive or in-depth look at it in terms of the NHS at this point.

Emma Harper: Journeys will still need to be made in relation to NHS travel. The Scottish Government has a switched-on fleets fund of £20 million. NHS Lothian is using it and Aberdeenshire Council has added 20 new zero-emission vehicles using that funding. We can measure those journeys and we know the mileage for NHS employees' travel.

However, I am thinking also about dialysis patients. They have very predictable journeys if they use taxis, which many of them do. We know the start point of the journey and the end point. We know that those journeys happen on Monday, Wednesday and Friday or Tuesday, Thursday and Saturday. The same patients have the same appointments every week. If Audit Scotland is looking for data to measure emissions reduction by replacing diesel-driven vehicles with electric vehicles, those journeys would be very measurable.

Should we consider doing that? Would we be able to get a big win if we rapidly adopt electric vehicles for patient journeys that we can measure and for which we can demonstrate emissions reduction?

Leigh Johnston: As I said, I just have not done enough work in that area to know whether that is the case, but I can flag the question to our climate change team. Audit Scotland has a team working

on the issue. It will be looking at the different ways in which we can consider how progress is being made in the public sector to meet some of these commitments and targets. I will pass the question on to that team.

Emma Harper: Okay. Thanks for that. I will halt there.

The Convener: Emma is giving out homework. [*Laughter.*] I want to move on to discuss preventative spend in greater detail. Gillian Mackay has some questions on that.

Gillian Mackay (Central Scotland) (Green): Given the increased pressure on waiting times and in other areas in the NHS as a result of Covid-19, is it realistic to move towards greater preventative spend in the medium term? May I go to Leigh Johnston to answer that first, please?

Leigh Johnston: Again, the focus is on recovery. Obviously, there is a backlog, which is very important to communities. In our "NHS in Scotland 2021" report, which was published in February, we identified that one of the risks of the recovery is that we lose sight of prevention and early intervention, which are key to reducing inequalities as well, in relation to equitable access to services. However, as we have said many times, we know that prevention and early intervention are not easy. They have been very difficult to achieve anywhere else. We have found that moving resources towards prevention and early intervention often requires a significant change in the way that services are delivered. It may involve reducing budgets in some areas, increasing budgets in other areas and targeting resources at specific groups of people.

Certain areas—community planning partnerships and integration authorities—have started to explore some small-scale preventative projects, but a significant scaling up of that activity is needed. However, that will require difficult local choices about what is prioritised as well as stronger, shared strategic planning for prevention across areas, because, as we discussed earlier, it is not just about health. Health services on their own cannot achieve prevention: implementation must be a cross-Government, cross-public sector, cross-third sector initiative.

Gillian Mackay: I will probably go back to Leigh for my next question as well. Is there an argument in the first instance—we touched on this earlier—for preventative measures to be taken in areas with higher excess mortality or where the number of healthy years of people's lives are expected to be lower?

Leigh Johnston: I do not know whether I have a particular view on that. I guess that I would argue that it is important across the board. It must be thought about in all areas. However, as I have said, there are specific groups of people that need resources targeted towards them for early intervention and prevention.

In its call for evidence, I think that the committee said that the Scottish Government's care and wellbeing portfolio board is at an early stage of development. However, one of its prongs is preventative and proactive care. Within that, I guess that the Government is committed to designing a new coherent and sustainable system that is focused on reducing inequality, prioritising prevention and early intervention, and improving health and wellbeing outcomes. As part of that, its objectives include a decision-making framework that prioritises prevention and early intervention, which I guess we would say is promising. However, we need more detail—we do not have enough detail as the work is in the early stages. It will be interesting to see how that develops and what possibilities it brings.

The Convener: David Bell would like to add to that.

Professor Bell: I am on the advisory board for an investigation into health inequalities in Scotland that the Health Foundation is carrying out. It might be of interest to the committee to hear about that report, once it is available towards the end of the year.

The Convener: That will come after our report next week. We are well aware of the Health Foundation's work on the area.

Professor Bell: Right. Okay.

There is a case for targeting preventative measures on those areas that have the lowest healthy life expectancy. Some areas are starting to think about things such as social prescribing. Bodies such as the Royal and Ancient Golf Club are buying up golf courses in deprived parts of Glasgow and trying to make that particular activity more accessible to people from more deprived backgrounds. Football is probably the sport that has done most to provide facilities and encourage people in deprived areas to get involved. At the end of day, that is the sort of thing that helps to increase activity levels, and we are pretty clear that increased activity is the thing that leads to better health outcomes in the long run. Again, however, that is the long run and, again, we need to understand how big that effect is.

Stephanie Callaghan: I have a question for Professor Bell. When we talk about the national care service, we are focusing on what matters to individuals and on supporting people to achieve the outcomes that they want. My thinking is that that is about their health and wellbeing. If they feel better, that is likely to improve their wellbeing, which can have a huge impact on health as well. That seems to be at the heart of the national care

service, so how much does that preventative impact fall into the bigger picture? I do not know whether I have explained that particularly well.

Professor Bell: A number of different things jumped into my mind. You mentioned people's choices. I should have said that I am not really clear about how self-directed support will fit into the new national care service or how it links with the disability payments that are being made through Social Security Scotland, but all those things are linked.

When it comes to achieving outcomes that relate to people's personal wishes for their health and wellbeing, there is a big question about the extent to which those are determined by people's own choices, rather than by what professionals think is good for them. I am not taking a view here about that, but that has to be part of the consideration of the design of the national care service. We also need to make sure that there is not double counting of the support that has been given to people. Self-directed support took off pretty slowly, but is now reasonably well embedded across quite a lot of local authorities. However, I am not clear about what role it will play.

Stephanie Callaghan: I have a short follow-up question. You talk about it often being the professionals who are leading things in a certain direction. Is there a place for something like an individual action plan that people would share with different health and social care providers in order to centre things back on their own priorities? When people are having those conversations it is easy for the options to be quite limited. That action plan approach could help, or would that fly in the face of things being based on data and evidence?

16:00

Professor Bell: Not really. Usually, there is no choice when it comes to healthcare interventions: if someone has appendicitis, they need an appendectomy. However if someone needs social care, the options for how that can best be achieved are much wider and it makes sense for the individual receiving the care, or their representative or guardian, to help to make those decisions. It is important that the national care service takes account of that. I am sure that that is part of the thinking, but exactly how that is done will be important for overall levels of satisfaction with that development.

Professor Wittenberg: I have two points. First, on the previous discussion, I took part in an evaluation of the well London programme, which was about prevention in deprived areas of East London. The outcomes were rather mixed. I can send the links to that study if it is of interest to the committee.

Secondly, on the topic of cash for care, my understanding of the evidence—such that there is—is that there is a big difference between different groups of service users. Direct payment is much more attractive to younger disabled people, who may welcome the opportunity either to employ their own carer or to be in control of the care that they receive, but for older people it has been rather less acceptable. This is anecdotal, but I spoke to a group of older service users who said that they saw it as a mechanism for the statutory authorities to transfer the burden of organisation to the service user, and away from the authority. It depends on the user group but, according to the evidence that I am aware of, for older people, it may also be that, in the use of cash for care or direct payments, the support services are very important.

The Convener: Our final line of questioning is on health and social care outcomes, which is a thread that has been running through everything.

Tess White: My question, which is around conflicting priorities and balancing outcomes, is for the whole panel, but I will start with Professor Bell. There are increased labour and drug costs, and capital costs, but there is also an immediate need to reduce waiting times and improve treatment times. How do you balance those immediate needs and outcomes with the longer-term outcomes?

Professor Bell: It is very difficult. Effectively, rationing short-term supply of healthcare and saying that we have to look to the long term is extremely unpopular, although it drives some people to the private sector—in fact, that is increasingly the case at the moment.

Ultimately, the Government should be driven by what works or is the best outcome among the conflicting alternatives. However, it is very difficult for Governments to avoid responding to short-term requests.

Unless you are prepared to countenance some different funding mechanism, it seems to me that short-term measures will probably win out and we will push further and further into the future the kinds of long-term strategy that we have spent a long time talking about this afternoon.

Tess White: Thank you.

The Convener: I will bring in the other witnesses; we will go to Professor Wittenberg first.

Professor Wittenberg: In the end, much of this is a policy decision rather than something that is readily amenable to analysis. In pure theory, I could probably imagine an analysis that looked at the gains in quality-adjusted life years from short-

term and long-term measures and tried to compare the two.

However, first, one is up against real difficulties to do with the evidence. Secondly, one cannot escape the issue of how to discount the future against the present—as you know, Treasury guidance is that future costs and benefits should be discounted, or regarded as less valuable than short-term ones. In the end, there is an element of judgment in that. My feeling is that it is probably not realistic to give a purely health economics, analytical answer; in the end, a lot of it comes down to policy judgments.

Leigh Johnston: I do not have much to add. We have talked about how challenging the health and social care financial position is. Not just in health and social care but across the Scottish Government, there are difficult decisions to be made. Those decisions are for Government and we cannot comment on where they should be made.

Tess White: It is almost as if the balance is between whether to put the wheels on the bus, because the bus is not moving, or to decide, strategically, where the bus is going. Have I heard that correctly?

Professor Bell: There is certainly a bit of that. It is a political choice.

The Convener: Emma Harper will ask the final question, unless other members want to come in in our final few minutes.

Emma Harper: We have talked about preventative spend, better outcomes and better health overall.

An example that comes to mind is how we keep people out of hospital in relation to asthma attacks or chronic obstructive pulmonary disease exacerbation. An overnight stay in hospital costs a minimum of £1,100. However, renewing a person's annual asthma plan and ensuring that people use their inhalers appropriately—whether they have COPD or asthma—can help to keep people out of hospital. Such support from a practice nurse or specialist in airway management and respiratory issues has to happen in primary care. Does that mean that we must take money away from secondary care and give it to primary care? Do we get an extra pot of money from somewhere?

Do we have a wee borrowing pot? Oh no, we do not, because we cannae borrow in Scotland. What is the best way to divvy up a pot of money?

Professor Bell: The kind of calculation that Raphael Wittenberg talked about would be more appropriate in this context, because the issue does not have big political overtones. It is possible to figure out what will give you the most bang for your buck, in terms of quality-adjusted life years—that is the technical term.

The issue then is the division of resource between hospitals, on one hand, and primary care, on the other. There is a question about how effectively primary care's case is being made for it when the division comes up in budgetary terms, and whether programmes such as you mentioned are deemed to be sufficiently important to warrant intervention.

That takes us back to data and the presentation of evidence as to how our overall budget should be allocated between—in this case—hospitals and primary care.

The Convener: I thank our three witnesses for giving us so much food for thought as we approach our budget scrutiny. Thank you for those helpful pointers, particularly as we also approach scrutiny of the National Care Service (Scotland) Bill. That is all that we have time for; thank you all.

Subordinate Legislation

General Pharmaceutical Council (Amendment) Rules Order of Council 2022 (SI 2022/697)

16:10

The Convener: The final item is consideration of a negative instrument. The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 6 September and made no recommendation.

The instrument's purpose is to allow the appeals and fitness to practise committees of the General Pharmaceutical Council to hold meetings or hearings using audio or videoconferencing facilities on a permanent basis. In-person hearings and meetings will continue to be available.

No motion to annul has been received in relation to the instrument. If members have no comments, do we agree that the committee will make no recommendation in relation to the instrument?

Members *indicated agreement.*

The Convener: Thank you, colleagues.

At the committee's next meeting, we will take evidence on winter planning for the NHS and social care. That concludes the public part of today's meeting.

16:11

Meeting continued in private until 16:30.

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

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