OFFICIAL REPORT
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Health, Social Care and Sport Committee

Tuesday 3 October 2023

Session 6

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
29th Meeting 2023, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Donna Bell (Scottish Government)
James Dornan (Glasgow Cathcart) (SNP) (Committee Substitute)
Stephen Lea-Ross (Scottish Government)
Richard McCallum (Scottish Government)
Rachael McGruer (Scottish Government)
Niamh O'Connor (Scottish Government)
Maree Todd (Minister for Social Care, Mental Wellbeing and Sport)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 3 October 2023

[The Convener opened the meeting at 09:15]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 29th meeting in 2023 of the Health, Social Care and Sport Committee. I have received apologies from David Torrance. James Dornan will join us as a substitute.

The first item on our agenda is to decide whether to take items 4 to 6 in private. Do members agree to take those items in private?

Members *indicated agreement.*

National Care Service (Scotland) Bill: Stage 1

09:15

The Convener: The second item on our agenda is an update from the Minister for Social Care, Mental Wellbeing and Sport on the National Care Service (Scotland) Bill. I welcome to the meeting the minister, Maree Todd, and, from the Scottish Government, Donna Bell, who is director of social care and national care service development, and Rachael McGruer, who is deputy director of social care and national care service development.

I invite the minister to make a brief opening statement.

The Minister for Social Care, Mental Wellbeing and Sport (Maree Todd): Thank you very much for inviting me to provide an update on the National Care Service (Scotland) Bill.

During the summer, we used the time to respond to stakeholder concerns. We have agreed proposed changes to the overarching structure of the NCS, which will help to achieve our ambition of improving the quality and consistency of social services. We have also carried out extensive co-design engagement across Scotland to understand how to achieve the change that is needed.

After being out and about over the summer speaking with people, I know more than ever that the status quo is not an option. We must act decisively so that people can have the improvements that they need as quickly as possible, and we must make wise decisions in a new fiscal environment in which resources are under pressure. That is not an easy task, but we are absolutely committed to getting it right by listening to the voices of experience. I want to outline how we propose to go forward, having listened carefully to those voices.

In my recent letter to the committee, I described our extensive summer programme of local co-design activity. We held regional events across Scotland and online. Hundreds of people participated and shared valuable and diverse feedback on the NCS. I attended several events in person, and I whole-heartedly thank everyone for sharing their experiences and knowledge. We have now published our analysis of those events. They will shape our thinking going forward and they will shape the second NCS national forum, on 30 October.

Our other major discussions over the summer were with the Convention of Scottish Local Authorities, the national health service and trade unions. We reached initial consensus on a

partnership approach with COSLA in July. That will provide shared legal accountability for integrated health and social care services. Those discussions are still continuing, and more detail is being developed that will inform our proposed amendments to the bill.

It is important that we have effective national oversight and governance to drive consistency and improved outcomes for people who access support. The proposed NCS national board will provide that.

At the local level, local government and NHS boards will retain statutory delivery functions and the staff and assets to deliver services. We are considering how local integration structures can be reformed and strengthened as part of the NCS.

Additionally, we regularly discuss the bill and current challenges in social care with trade unions. Although we are limited in legislating on employment, we are committed to promoting fair work as far as possible through ethical commissioning and procurement. We will provide funding to increase the pay of social care workers and to improve workforce planning, practice and culture, and we will take into account trade union views on issues such as workforce representation in designing the national board and local delivery.

In summary, I say that the summer was very busy, with many productive discussions and positive developments.

I hope that that is a useful overview before our discussion.

The Convener: Thank you very much, minister, and thank you for attending the meeting.

As you said, the summer was obviously very busy, with a lot of engagement across the country. Can you expand a little on what you said in your opening statement about the impact that the accord with COSLA and shared accountability will have on the national care service and the relevant provisions in the bill?

Maree Todd: There are a couple of important things to draw out about shared accountability. It is shared, rather than joint, accountability, which is a significant distinction because we have different groups to which we are accountable.

As ministers we are accountable to the country; local authorities are accountable only to the local authority area that they represent; and the national health service is accountable to the NHS boards. We all have different groups to which we are accountable, but if we share that accountability we get really good coverage and oversight of the country. The three of us together will definitely have an impact in terms of delivery of better standards and qualities.

We are still working out the detail around the national care board, but I do not think that it will be just the three of us. There will be more people around that table. I expect that there will probably be an independent chair. I think that the voice of lived experience will be absolutely vital on that board, and I think that it should include representation of the workforce and the national social work agency. Those are the things that will give that board teeth and make sure that it delivers an impact.

I have heard criticism from many people that the board is just the status quo, but it will be different. At the moment, I have no control over the social care system; I am held to account day in and day out for things over which I have no control. In the future, Scottish Government ministers will have some control, which they will share with a national body. That will absolutely ensure that we deliver improved standards.

The Convener: Thank you for that. You have covered a bit of my next question. This issue has been raised with me, as an MSP, and I am sure that it has been raised with you, as minister. It is about individuals who are disappointed that accountability will be shared because one of the recommendations of the Feeley report was that there would be ministerial responsibility. There is concern that, if responsibility and accountability are shared, the existing postcode lottery—as people see it—of access to care services will continue. How will you ensure that that is not the case?

Maree Todd: I hear that criticism loud and clear. I hear it very directly because we are engaging so closely with people who have lived experience of accessing care. Undoubtedly, there are many people for whom the situation with access has been traumatic and disappointing. They are absolutely clear that change is required, as am I. As I said, the shared accountability that we foresee will, I think, give ministers control over the system, while ensuring that local delivery is still done by the local democratically elected body. That is probably the best combination.

It is really important that the board has the power to take action when there is system delivery failure, so I am determined to reassure people that it will have sufficient power to take action when it needs to. We are envisaging something similar to the arrangements that are currently in place for health boards, where there can be intervention, if there are challenges, and escalation of interventions. We envisage something similar for the national care service, in that its board will have the power to intervene.

The Convener: What would become of health and social care partnerships? How would they

relate to the national care board in terms of governance?

Maree Todd: We are still in the thick of discussing local governance arrangements. I might ask officials to come in on that, in case I have missed anything in answers that I have given. However, I envisage that the structures that already exist will be strengthened.

At the moment, we have quite a disparate pattern of integration, which is one of the reasons why we have a postcode lottery. There is more integration in some parts of the country than there is in others, which is probably not serving us particularly well. There will be a move towards more integration all over the country, and the structure of integration joint boards and health and social care partnerships will evolve and probably strengthen in order that they can oversee local delivery of social care.

Donna Bell (Scottish Government): There is a distinction to be made between integration joint boards and health and social care partnerships. IJBs have a legal foundation, but health and social care partnerships are a way of working. That sometimes creates a bit of confusion. We are keen to bring a bit of clarity about accountability and how all that works, as we go along.

The Convener: Do you want to bring in your other official?

Maree Todd: Do you want to say anything more, Rachael?

Rachael McGruer (Scottish Government): No. I will just reiterate what the minister said about the discussions being under way and that we have to work out exactly how we can strengthen local integration under the model.

Evelyn Tweed (Stirling) (SNP): In the programme for government, there was a pledge to set £12 per hour as a minimum rate of pay for all social care and support staff. How will that be implemented effectively?

Maree Todd: During the past number of years, we have effectively introduced a floor level of payment of social care staff. We have introduced that nationally, and we did so by providing funding to ensure that that pay can be passed on to staff. I think that we will manage to do so again using the mechanisms that we have used for a number of years. I am absolutely delighted that we are delivering on that commitment.

I know that people are, as ever, pushing for more and would like even better pay in social care, but I am absolutely delighted, given the financial constraints that we face as a nation, that we are delivering on that, and that we are setting a path of year-on-year significant improvement in pay for social care staff, because that is one of the very important things that we need to do to strengthen the system as a whole.

Evelyn Tweed: How can ethical commissioning change the nature of contract competition?

Maree Todd: One of the challenges that the Scottish Government has is that we do not have control over employment law. We would like to see many changes in the employment of social care staff in the sector, but we do not have the power to intervene directly. Ethical commissioning gives us some power to ensure that, where we use public money, staff are treated well. That is an important part of what we hope to achieve with the national care service.

When I think about the change that we are trying to make, the two groups of people whom I have in mind, day in and day out, are the people who access care—from whom I hear every day about just how difficult that can be—and the people who work in social care. I am pretty confident that ethical commissioning gives us a tool with which to improve their pay and conditions, to hear their voice and to build fair work principles into the procurement process.

Donna Bell, do you want to say a little bit more about that?

Donna Bell: Yes, I am happy to do that. Current procurement legislation provides the opportunity for ethical commissioning. The National Care Service (Scotland) Bill, as introduced, places duties on ministers and care boards to produce ethical commissioning strategies as part of their strategic plans, which is a key part of implementation. There will be an opportunity, through that, to support consistency and enable us to focus on the important issues that the minister has already picked up.

We have some detail to work through on what exactly those ethical commissioning strategies will look like and what will be the expectations that sit behind them, and then to implement them. However, I certainly think that the bill is a very important step towards embedding that in all our social care practice and beyond.

09:30

The Convener: We move to Carol Mochan, who is joining us remotely.

Carol Mochan (South Scotland) (Lab): Good morning. I am interested in a couple of issues that follow on from Evelyn Tweed's questions. Will you give us some idea of how sectoral bargaining might operate within the care sector in the future across the public sector, the third sector and the private sector?

Maree Todd: Sectoral bargaining is probably the toughest area to deliver and a lot of work is going on in that regard. Usually, it is fairly straightforward once you define the sector, but even defining the sector has proved to be difficult in this sphere. It is very complex, and the way in which care operates in Scotland is pretty complex.

Generally, in sectoral bargaining, there is discussion between a group of employees and an employer or two. Clearly, there are multiple employers in social care. Government also has an interest, because we provide a lot of the money to pay for commissioned places and to increase wages. As a result, more people are around the table than there would normally be in a straightforward case of sectoral bargaining.

We are getting into the detail of it now, though. On the recommendation of some of the trade unions that we work with, we have approached a couple of academics and involved them to help us to unlock the discussions and make progress. I am reasonably confident that we will make progress on sectoral bargaining, which will be crucial to the delivery of fair work in the future.

Carol Mochan: Lovely—that was very helpful. You mentioned engaging the trade unions. I am assuming that you will assure us that you will continue to work with the trade unions as we go through the National Care Service (Scotland) Bill.

My last question is, to what extent and in what ways do you expect the new accord with COSLA on shared legal accountability to address the concerns of trade unions about the bill? How will that agreement work as we move towards the national care service?

Maree Todd: You are absolutely right: the trade unions will be crucial to the development of the national care service. I spent a lot of time working with them over the summer, and I would expect that work to continue.

I have said a number of times that one of the reasons why the social care workforce is so disadvantaged is that it is largely female and barely unionised. It is 83 per cent female and there is less than 19 per cent unionisation. I would like there to be a stronger role for unionisation within the workforce, in addition to me working with the unions to develop the national care service.

In terms of the shared agreement, I have mentioned the national care board. The board will be broader than just ministers, local authority representatives and NHS representatives. I would expect the voice of employees—the voice of people who work in social care—to be at that table as well. I would envisage an on-going space at the table for dialogue with them.

We envisage that the national social work agency, which will not be a union but a professional organisation, will be a strong voice for social workers in the national care service. Social workers are key to effective delivery of the ambition that we have set out. There will be a strong role for people who work in the sector, not just in the development of the national care service but in the on-going delivery and the national governance of that delivery.

As I said, I cannot commit to those things yet, because we are still discussing it. Today, I am laying out how I envisage that taking shape.

The Convener: I will pick up that theme of engagement with trade unions. I declare an interest as a member of Unison. Minister, do you envisage that there will be any specific changes to the contents of the National Care Service (Scotland) Bill following your on-going discussions with trade unions?

Maree Todd: I am wondering which of my officials is best placed to answer that. We are working with the unions on amendments.

Donna Bell: I cannot recall how many questions we received from the unions, but there were quite a lot, which is totally reasonable. We have been working through amendments with them and on further amendments that we might need to make. We have not yet reached any conclusions, but that dialogue is certainly under way.

The Convener: Thank you. We move to our next theme with questions from Emma Harper.

Emma Harper (South Scotland) (SNP): Good morning. I am interested in the co-design process. I know that regional events on that took place over the summer, at which you focused on rural as well as urban issues. For example, in my area such events were held in Stranraer and Hawick. I would be interested to hear a little more information about the co-design process and whether it was different from other processes that had taken place previously.

Maree Todd: Generally, when we go out to consultation there is a set of proposals on the table. When we have gone out to speak to people, one of their criticisms has been that there is not enough meat on the bones. We would usually have a set of proposals and we would ask people whether they liked them. We have taken a step back from that approach and adopted a co-design process, spending a great deal of time understanding the current situation and trying to imagine a different way of doing things that would deliver better.

That is a step back, I think, from consultation. It delivers the voice of lived experience right at the heart of the design of the national care service,

which is really important. I do not envisage that process having a hard stop at the end, when the bill is delivered. I envisage the voice of lived experience continuing to be a strong part of how the national care service evolves. It will help us to get the policy right in the first place and to deliver it according to our ambition.

Is that sufficiently clear for you or should I bring in my officials to give a little more detail?

Emma Harper: I am interested in the fact that we are taking a step back to involve people right at the beginning. Involving people with a wide range of experience does seem to be valuable.

We have heard about the support that is required right across the social care spectrum. Here I should probably remind everyone that I am a registered nurse. Over the summer, I spent time visiting the social care delivery team at Stewartry Care in Castle Douglas. Its work is varied and the people there are skilled and competent in delivering care for people in their own homes.

I am keen to ensure that people understand what the co-design process is. They might just assume that co-design and co-production are the same thing, but they are not. Did that point about there being co-design and not co-production come out in the consultation process?

Donna Bell: I am happy to say a bit more about that. As the minister said, the response was fantastic. We had more than 500 people at our in-person events and hundreds at the online ones. We thank those people for giving up their time.

The people to whom I spoke found it to be a valuable process but quite a different one. We were not presenting them with proposals and asking whether they liked them. Instead, we were getting into the depth of their lived experience and their understanding of how the current system works for them.

The five co-design themes were: keeping care support local; information sharing; making sure my voice is heard; realising rights and responsibilities; and valuing the workforce. It is also important to say that when we talk about lived experience we mean the experience of people who work in the sector as well as that of those who receive support or services.

The reports were published last week. We could send the link to them to the committee if that would be helpful, convener.

There is excellent information and insight in there about how people feel and how they engage with services, which will, as the minister said, help to inform delivery of the bill and the national care service more broadly. I could go into a lot of detail about that; I will not, but I am happy to answer any further questions.

Emma Harper: There is a lot of information from the six reports on the Government's website, and they are available in an accessible format. The reports are pretty comprehensive. I will probably need to read them in more detail, but I appreciate that.

Maree Todd: Co-design delivers a sense of empowerment—it really is about empowering people. It is about handing the power over to them and saying, "If you were in charge, what would you do? How would you do it? How would you design a service?" We hear from people time and again about where things go wrong and how difficult that feels, so it is about making sure that we get it right from the conception stage rather than just rubbing the edges off delivery. I have heard from people who are involved that it feels very different. They say to me, "We have been saying these things for years; it's not like we're saying anything new." The difference is that the system, which includes us all, is now listening, which is an important part of the process.

Emma Harper: I have a final quick question. You talk about empowering people. Over the past few years, I have heard people say that they want to work with people to support their care, not to do stuff to them. Are we making progress on the language in relation to working with people rather than doing stuff to them?

Maree Todd: Definitely. The first time that I met the social covenant group, it corrected my language. I made the rookie error of talking about person-centred care, and members of the group said, "Excuse me, minister, it is person-led care," so they absolutely want to be in charge. It was a useful early lesson for me to listen carefully to what people are saying and always to make sure that they are in charge and as independent as they possibly can be. That is part of the purpose of designing the bill in this way.

The Convener: It would be helpful to the committee to receive that additional information from Ms Bell or the minister.

Paul Sweeney (Glasgow) (Lab): Thanks to the panel and the minister for attending today. There has been confusion about what co-design means and how it differs from consultation, so could you clarify exactly how much influence the learnings from this summer's forum events will have? Are they geared towards how the national care service will operate in relation to the processes and procedures or the design of individual services in specific areas or in the territorial boards?

Rachael McGruer: I will give an example to help to bring co-design to life. We did work over the summer under the realising rights and responsibilities design theme. We are committed to a charter of rights and responsibilities for

people. We took the draft charter out to individuals in those sessions, and they have helped us to make sure that it is meaningful to them and that they feel that it has teeth. That is an example of direct working together on design. We want to use that principle in the development of the workforce charter.

Co-design is about getting people around the table and working together to help to find a solution, which is quite different from the traditional consultation approach.

Donna Bell: On the framing of the work that we are doing, as my colleague said, in areas such as the NCS charter, the workforce charter, informing the bill and, in due course, the national board, we are not at the point of doing any service design.

As Maree Todd said, as we move into the implementation of the national care service, there will be a strong expectation that co-design will form part of the future of service design in the national care service in Scotland. Does that help, Mr Sweeney?

Paul Sweeney: I think that it does, and it brings us neatly on to the point about the charter being critical; it will be the linchpin of how the service will operate. There was a bit of dispute about having the charter in the bill. Will that opportunity be taken now, given that a draft has been produced and has gone out to consultation as part of the co-design process? Will Parliament be able to have sight of that and to codify it? Is it the intention of the Government that the NCS charter and the workforce charter be in the bill?

09:45

Rachael McGruer: The expectation is that we should have a form of the draft charter to share with the committee by early 2024. As the charter is co-designed—and co-design is an on-going process—to ensure that we have the ability to make the process iterative and for people to work with us, the preference is that the charter will not be enshrined in primary legislation. That is the intention, but we will definitely look to share a draft with the committee as soon as we think that it is in an appropriate format.

Paul Sweeney: At what point does the charter become stabilised as a codified document? Is it the intention that it will be codified? You said that it is a fluid process, but clearly at some point it will have to be finalised, agreed and ratified by all the stakeholders. At what point do you envisage that that will happen?

Rachael McGruer: We are currently in the sense-making phase of the co-design process. We will work through the different phases of the process, and then at a point when we feel that we have reached agreement as to the solid status, we will look to codify it. However, we want to review that document regularly and ensure that it is not set aside, because we need to ensure that it is meaningful. One of the reasons that we have enshrined co-design as a principle in the bill is that it is an on-going commitment of the national care service to check the charter, as part of a process of continuous improvement.

Paul Sweeney: Could it be an option to have the initial codified version of the charter in the bill—even if it was added at stage 3—and then have provisions in the bill so that the charter could be amended in the future through delegated powers? That would at least make it a focus point in the bill. The NHS charter is very much the focus of the Patient Rights (Scotland) Act 2011, so it would be nice to have the charter feature as part of primary legislation for the national care service. Might the Government consider that?

Maree Todd: We will certainly consider it. I will not give a promise today, because we need to discuss that with drafters and get technical guidance on whether doing so is a possibility, but we will certainly consider it and get back to you about whether it is possible.

Paul Sweeney: Okay, thank you. My next question is also on the co-design process. There have been a lot of regional events to ensure that there is geographic coverage, but what other methods did you undertake to ensure that as many different stakeholders—underrepresented voices, in particular—as possible were given sufficient opportunity to input to the process?

Maree Todd: I will bring in Donna Bell in a second.

As well as all of the regional events during summer, we have since added another three regional events, because of popular demand. We have a national event at the end of October, and we also held online events for people who could not attend in person. We have commissioned some specific work, with specific partners, to go out and reach the groups that, when we looked at the information that was coming in, we felt we did not have 100 per cent coverage.

Donna Bell: I will just mention what we have done to follow up with those seldom-heard voices. We want to ensure that we maximise the reach of this work, and we continue to do that as we go along, so if we review the evidence that comes back from the co-design process and see that there are groups that are either underrepresented or not represented at all, we proactively seek input from those people. Going through colleagues in the third sector is quite often a good way of doing that, so we provided grants to a few organisations

to provide some supportive engagement with the co-design process.

Paul Sweeney: That is very helpful.

The Convener: I am going to stay with Mr Sweeney to lead on the next theme.

You are on mute, Mr Sweeney.

Paul Sweeney: Sorry. Unfortunately, I do not have control of my mute button. Apologies for that.

I will move on to proposals for delivery of services. We know that there is a postcode lottery in access to social care services. How does the Scottish Government plan to improve access in the new structure of the national care service?

Maree Todd: How we improve access will be crucial to the success of the delivery. We all pore over the delayed discharge figures, particularly coming into winter. We are less good at capturing the level of unmet need that we know is in the community for people who seek care packages and have been assessed, but are not able to get them, which is equally important. We know that accessibility at every step is a challenge.

One challenge that we face is that there are different levels of integration around the country. As I have said, that makes it difficult to know where services are falling between cracks. We think that services sometimes fall between cracks because of the accountability in different models of design.

I see the national care service as the natural next step in integration. This is about further integration. We see different models of integration around the country. In some parts of the country, mental health is included; in other parts, it is not. As I have said, that gives rise to some of the postcode lottery and some of the challenge in taking steps to improve accessibility. We will look at whether that serves the nation well. The issue is probably improving integration in every part of the country.

The national social work agency will produce national standards. That will be an important part of improving delivery and ensuring that everywhere operates to the same national standard. I think that that will give protection to individual social workers, who will know what they need to do at each step of the way in their jobs. That is really important.

As I have said, I am determined that the national board will have teeth, so it will not be there just for decoration. It will absolutely be there to take an overview and to take action if there is service delivery failure in any part of the country. Where problems arise, the national care board will be able to take action to correct them.

One thing that will be really important—I think that we spoke about this when I was last at the committee—is the review of independent inspection and scrutiny that has just reported. We as a Government still have to reflect on and respond to that, but I think that that will provide us with another lever to pull to improve the situation and the standards nationally. Getting the inspection and scrutiny process right is a really important part of the process. One of the aims is to shift from what is perceived to be a punitive system in which there is reputational damage if things fall short to a more supportive system in which there is an ethos of continuous improvement and support is easily available to try to improve standards where they are found to fall short.

Paul Sweeney: The point about continuous improvement, benchmarking and bringing everyone up to the highest common denominator is a helpful insight into the Government's aspirations. However, an issue was brought up in discussion with the cabinet secretary. Last month, he told the committee that scrapping non-residential care charges by 2026 was not necessarily going to be achievable any more and it certainly was not going to be a key priority going forward. How does the Government propose to address the postcode lottery without scrapping non-residential care charges? Is that being considered in the development of the national care service?

Maree Todd: As far as I know, that commitment still stands.

Donna Bell: It remains.

Maree Todd: We are in exceptionally difficult fiscal times at the moment. I do not think that there has ever been a more challenging time to be in government in terms of finding the money to deliver the commitments that we have made, but I am operating on a proceed-until-apprehended basis. Nobody has told me that we are not doing that, so, as far as I am concerned, we are definitely doing it.

Paul Sweeney: That is reassuring. Thank you very much.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): Good morning, minister. You have touched on some of this already, but what is the Scottish Government doing to support local authorities and health and social care partnerships with the current and immediate issues in social care and to support provision, including, for example, on staffing and capacity?

Maree Todd: A lot of work is being done. Obviously, the delivery of £12 an hour is key, and I think that it will help, but it is not everything. As well as improving pay, work is going on across the

board to improve conditions, focusing initially on maternity leave and sick pay—that is one of the fair work strands. Work is also going on with the Scottish Social Services Council and NHS Education for Scotland to provide educational opportunities to support the social care workforce so that, when people come into it, they feel well supported, know what they need to do, and have clear pathways to improve and to further careers, should they wish to study and move on.

As I say, a great deal of work is going on across the board, and not all of it requires primary legislation to happen—we can deliver some of it without primary legislation. A transformative change is required if we are to achieve one of the things that I hope we will achieve, which is an increase in the status of social care. I would love it if, in Scotland, we were talking about social care not just as something that helps the NHS when it is in trouble or harms the NHS when it is not functioning right, but as something that is valued in its own right and for its inherent ability to change people's lives.

Social care totally transforms the lives of people who can access it, and it transforms their families' lives. Day in and day out, I meet carers who are stretched to the limit trying to cope with the situations that they are in. An effective social care system takes the burden off families and it contributes to communities and to the economy. We talk a lot about the cost of social care, but we do not talk quite so much about its value. I am determined to move the conversation on to the value. On a very regular basis, I meet people who are struggling to work because of their caring responsibilities. If we get social care working right, it will have an impact on the economy. If we can articulate that better, we will stop thinking quite so much about the cost and start recognising the value, which is what we do with the NHS.

Stephanie Callaghan: You are absolutely right. I am sure that we can all agree on how valuable social care is, and the pathways that you spoke about are so important, too.

I would like to ask you about the end of life. Not everyone will recover, and a substantial portion of the current health and social care budget is spent on caring for people who are approaching the end of life. At a previous committee meeting, Mark Hazelwood, the chief executive of the Scottish Partnership for Palliative Care, called for changes to the principles of the bill to include end-of-life care. How will the national care service be developed to respond to the growing need for palliative and end-of-life care? How are co-designed forums informing that approach?

Maree Todd: Donna Bell can probably give more detail.

I have not been asked very much about palliative care. However, the reality is that the vast majority of people who go into a care home do so at the end of their lives and they pass away within an 18-month period. It is there, but it is not up front. I will let Donna Bell talk a little bit more about that.

10:00

Stephanie Callaghan: Talking about that final year of life, there are also all the hospital admissions and so on. We are always talking about bringing down the number of admissions, but obviously that is something that is not quite so movable.

Maree Todd: Absolutely. I am absolutely determined to improve the situation, particularly because of where I live. The geography where I live is very challenging for social care. We do not have a care home in the village that I live in. If someone is unable to manage independently in their home in my village, they have to move away from their community and family to access care, probably on the other coast. That is the reality for people in the Highlands.

One of the reasons for our focus in the national care service on shifting care upstream and getting into that early intervention and prevention end of things, to support people to live independently and healthily at home for as long as possible before care is needed, is about enabling people to grow old and frail, and potentially die in their own communities. We are determined to deliver that. I will hand over to Donna Bell to give a bit more detail on palliative care.

Donna Bell: We have engaged very broadly through the co-design process, particularly with people who have looked after relatives who have received palliative care. We have avoided naming multiple conditions or situations in the bill because people find themselves in many different circumstances. The importance of the charter is crucial here: dignity, respect and equalities are going to be critical, particularly in palliative care. We want to ensure that the aspects of the charter that we want to draw out can be applied across all aspects of people's care, not just to palliative care specifically. However, those aspects would have a clear role in ensuring that people have the dignity and the care that they need as they go through the palliative process.

I hope that that answers your question on what is in the bill. There are other mechanisms to draw all of that in. We would be very happy to look at that and to pick up on palliative care with Mark Hazelwood.

Stephanie Callaghan: Are you getting the feedback to help to inform the charter through the

national care service forums or is there more work to be done in that area?

Donna Bell: There is always going to be more work to be done. We are getting some really good feedback, particularly on the charter, about how those rights can be made to feel real and on how clear they are. One of the key things was to make sure that the charter is unambiguous so that people can really see what their rights are and how they can hold partners and the accountable bodies to account for those rights. We are getting that feedback. However, as the minister has already said, we will continue to have that engagement. We have not just the individual lived experience panel of experts, but also the stakeholder register, which has more than 300 organisations on it.

Stephanie Callaghan: Great, thank you.

Tess White (North East Scotland) (Con): My questions are on the current status of social care. The national care service will cost upwards of £1.3 billion and is already overdue. You have said this morning, minister, that there is a great deal of work going on, but you also said that you currently have no control over social care. What are you able to do in the interim period to support the current social care provision?

Maree Todd: One thing that we are doing is putting a lot of extra money into social care. We have made a commitment during this session of Parliament to increase the amount that we spend on social care by a quarter, which would mean £840 million going into social care. We are already at £800 million, so we are ahead of the trajectory on that and are vastly increasing the amount of money that we put into social care.

If I am correct about what you are asking, it is about whether we should pursue structural change at a time when the system is under so much pressure. Derek Feeley was clear that, if we just keep doing the same thing again and again, we will just keep getting the same outcomes, and we are clear that the system is not working as we want it to for the people who are accessing care at the moment. We need a transformational whole-system change to be delivered to meet the aspirations of the nation.

Tess White: Minister, I was asking about what you are doing now. It is great to hear about the £840 million but what is that being spent on?

Maree Todd: It is going on things such as increased wages. We have drastically increased the amount of money that people who are working in social care get paid. In the past couple of years, they have had a 14 per cent wage rise. That is one clear improvement that will be felt by everyone who is working in social care. People who work in social care in Scotland are now paid more than their counterparts all over the United Kingdom.

There is more to be done, but that sets us on a clear path, and I expect to do more of that.

Tess White: You are saying that that £840 million is going on public sector and private sector pay increases.

Maree Todd: Yes, because we have a mixed market.

Tess White: Thank you.

In 2015, Shona Robison pledged to end delayed discharge. Why, after such a long time, has the social care sector not been given the resources to end bed blocking in the NHS?

Maree Todd: That is a tricky thing to fix. If it were easy to fix, we would certainly have done it by now. Lots of work was being done across the system all last winter, and as soon as the winter was over, we began to reflect on how to rise and face the challenges that we expect to be faced with again this winter.

Scotland's situation is not unique; it is similar all over the United Kingdom and in many developed countries. There are a number of challenges. As your question implies, there is no doubt that we were not rising to the challenge of delayed discharges prior to the pandemic, but we are now in a really difficult situation because of the pandemic. The whole of our health and social care system has been under sustained pressure for a number of years, and that is one the reasons why we are in such a difficult situation on this issue.

Of course, we have to cope with a new condition and several hundred people will be in hospital today with Covid and Covid-related complications. There is, therefore, a whole extra condition to be coped with as well as the fact that the staff and systems have been under sustained pressure for the past three years during the pandemic.

What are we going to do to improve the situation? That is the crux of the issue: how are we going to move forward from where we are now? A lot of work is being done across the system, including a lot of collaboration with local governance systems. We are producing dashboards of data, so during the past few months, we have spent some time on improving the data that we can provide to ministers and to local governance structures to try to ensure that quick action is taken where problems are brewing.

There is a suite of things that we know work, such as discharge before 12. Programmes such as home first are in place. That is an interesting programme and early results are impressive, so we probably need to ensure that that programme increases at pace and is delivered at a high level

right across the country. In that programme, instead of an in-patient waiting for an assessment in a hospital environment, they are discharged to their home and assessed there. The clear finding is that a smaller package of care, with immediate support, is required to support people at home if they are discharged quickly. We are striving to spread that practice all over the country.

There is a lot of work to be done, but there is no magic pill. If there was, we would do it, and everyone else in every other country in the UK would be doing it, too.

Tess White: Thank you. It sounds as though you are doing a lot of work on delayed discharge.

Maree Todd: Yes.

The Convener: I move to Sandesh Gulhane, who joins us remotely.

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

Minister, since the Scottish Government's decision to go back out to consultation, what has been the cost to the taxpayer for the National Care Service (Scotland) Bill to tread water?

Maree Todd: I would challenge that narrative. We are not treading water. This is the second time that I have been in front of this committee to explain exactly the level of work that is going on across the country.

We paused and then worked very hard with partners, local government, trade unions and people with lived experience to try to find a way forward. You will be aware that we were pretty much in a situation in which we could not move forward because the level of opposition to the bill was so great. Therefore, I am really pleased that we have achieved consensus and that we are moving forward now.

I think that, last week, we provided the Finance and Public Administration Committee with costs for the bill so far. If you check the papers for that meeting, you will be able to see exactly how much spending there has been on the bill at each stage.

Sandesh Gulhane: What is that number, minister?

Maree Todd: I do not have the numbers in front of me at the moment, but it is significantly less than was predicted because the pace of delivery is slower. The slowing of the pace, the pausing and the phasing of the introduction of the national care service mean that it is costing less.

Donna Bell might have the table in front of her.

Donna Bell: I do not have the table in front of me. We probably also need to make a distinction as work would have been under way anyway. We had always planned to do the work on co-design over the summer. Stage 1 of the bill will now be completed by 31 January 2024.

It is quite difficult to make a judgment on whether there has been a cost to the delay or not, because the effect has simply been that the work that we had planned to do has been rescheduled. As Ms Todd said, we have provided information on the costs to develop the bill and the programme of activity. The bill is one part of the work. Various engagement activities are under way, as are policy development and broader activities.

We can certainly provide to the committee the information that we provided to the Finance and Public Administration Committee on spend to date on the bill, if that would be helpful, convener.

The Convener: Yes, I think that that would be helpful. Thank you.

Sandesh Gulhane: Let me get this straight. The Government created a bill. You said to me, minister, that despite the significant opposition to the bill that the Conservatives brought up and discussed many times, the Government said that it was just going to press ahead, but that, because of that continued opposition to the bill, you stopped to reconsider. However, you do not consider that to be treading water, and you do not have figures to tell me what the cost was.

If I say that the figure is £15.4 million, would that be accurate?

Maree Todd: I am really sorry, but I did not hear that figure. Could you repeat that figure, please?

Sandesh Gulhane: £15.4 million.

Donna Bell: I do not recognise that.

Maree Todd: No, we do not recognise that figure.

I did not say that the Conservatives slowed the delivery of the bill. The Conservatives were one group that was opposed to the bill as introduced, but there was significant opposition to the bill as introduced. I think that it is reasonable in the face of significant opposition that the Government pauses and works on the direction of travel with the people who are concerned about the direction of travel, and that is what we have done.

The bill will be delivered. We will finish stage 1 by the end of January next year. Of course, it will be down to Parliament how fast the legislation progresses, but I would expect there to be significant progress in the next few months.

Sandesh Gulhane: Okay. Thank you, minister.

10:15

Emma Harper: Just to go back a bit, I recommend that people look at the Government's website. There is comprehensive information on the national care service, with all the reports and information on the engagements over the summer and the work that has been done to connect locally. It is great that Stranraer was one of the places involved, because folk fae Stranraer always feel forgotten.

How does the Government get the message out that people should look at what is on the Government's website to find out about the power of work that has been done over the summer? What is the best way to share that information?

Maree Todd: That is a good question. There is a lot of work and a lot of evidence there—perhaps there is almost too much, and people are finding it hard to navigate the volume of information. We can reflect on how to communicate. We have specific forums where we meet, hear from and talk to people with lived experience. We also have on-going engagement with trade unions, which has been vital to improving communication. When I first came into post, a number of people were concerned about things that just were not correct. Correcting those myths has been an important part of the work that has been done during the pause.

We have a social media programme, which is a really rich way to bring the information to life. As members, we all love reading, and we read a lot for our work, but it can be tough for Joe Bloggs to read through pages and pages of information in somewhat dense text. There are "Voices of Care" videos that bring to life different aspects that we are working on. I recommend that people have a look at those, as they really bring to life what we are trying to achieve.

Emma Harper: My question is not a criticism; I am just raising the fact that there is comprehensive information out there. There are easy-read documents for people, and the videos that you referred to are another great way for folk to get information—they can watch the videos on their phones or whatever. My point is that a lot of work has been done over the summer and it would be good for people to be able to see that.

Maree Todd: Absolutely. We will certainly reflect more on how we can highlight that to folk. You are absolutely right that there is a lot of detail out there.

The Convener: I have a question for the minister or the officials, just for clarity. The figures that Sandesh Gulhane was asking for were made available to the Finance and Public Administration Committee, so are they published?

Maree Todd: I think that we sent a letter with those figures.

Donna Bell: Yes. We can certainly provide the figures to this committee, if that would be helpful.

The Convener: That would be very helpful—thank you.

Gillian Mackay (Central Scotland) (Green): Good morning. Some unpaid carers are concerned that the pause in the national care service might mean a delay in the right to breaks from caring coming into place. Will you update us on what work is being done to progress that while the bill is still being worked on?

Maree Todd: You are absolutely right. It is crucial that carers have a life alongside caring. I mentioned that I meet regularly with many people who are involved in social care. People who are caring for members of their family are often at the end of their tether, which is one reason why I am absolutely passionate about shifting care higher upstream towards early intervention and prevention, so that people do not get to crisis point before help is available to them.

It is absolutely crucial that carers have their own life alongside caring and that they can sustain their own health and wellbeing. As you are well aware, we are doing a lot of work through the bill to enshrine the right to breaks. However, we are acting now to expand easy access to short breaks support ahead of the legislation—we are not waiting for the legislation to make that change. We increased the voluntary sector short breaks fund by £5 million to £8 million, and we have maintained that fund at £8 million for 2023-24.

That is in addition to the Carers (Scotland) Act 2016 funding—the £88.4 million that goes through the local government block grant. We are trying hard to support carers before we create their right to a break by putting it in the bill.

Gillian Mackay: The money is hugely welcome—I am sure that we all welcome it. Another particular concern that has been raised with me is that there is geographical variation in the ease of access to breaks—you will be well aware of that, minister, as a rural constituency MSP—and also variation in the support that is available. Not everyone will want what I am sure many members of the general public have traditionally seen as short breaks. Many people want to be able to take their loved one with them on holiday and to be supported to do that.

What specific work is going on in those two areas—addressing geographic variations and improving the diversity of short break offerings—in order to make sure that we will be ahead of the game by the time the provisions in the bill come into force?

Maree Todd: That points to the fact that, as I keep saying, one size does not fit all. One general thing that we are trying to do with the bill is to make the approach more person centred—or person led, to correct my language as per the social covenant group guidance. We want it to be flexible and we want it to work for the people who need the support, so we will need to work really hard on the ground to ensure that there is a person-led approach to carer support.

I have been asked before about a definition of "sufficient breaks". We could toil and come to an agreement on the definition of that, but the more important thing is whether the person who is accessing the support feels that they have had sufficient breaks.

As in all things, we need to build something that is flexible, person centred and person led, and which delivers the difference that we are hoping to see. That will be tough. At the moment, as you say, we have a variety of options across the country, some of which are easier to access than others and some of which are more enticing than others. However, we are already working pretty hard right across the board to improve that situation.

I do not know whether either of my officials wants to say anything.

Rachael McGruer: To build on what the minister has said, I note that, as part of our co-design and our stakeholder engagement, we are working with the stakeholder working groups on that very issue. They are helping us to define what "sufficient breaks" look like and mean to them. The groups include representatives from island and rural communities. It is a very live issue and one that we have been discussing with them. It is really important that they have their voices heard to help us to work that through.

I was in a conversation just last week about the reality of what "sufficient breaks" means to a carer. This is where the voices of the unpaid carers in the room are really important, as well as the voices of the local carer centres, which understand their communities' needs. We are very committed to working with them to help us to develop the regulations and guidance, in order to make sure that we truly deliver as consistently as possible across the country.

Gillian Mackay: That is great. Thank you.

The Convener: Tess White has a brief follow-up question.

Tess White: Minister, you recently told social care providers in Shetland:

"it's not our intention to come up here and tell you how to do things".

How will the independence of local providers be respected when you are centralising social care across Scotland?

Maree Todd: Again, I challenge that narrative. We are not centralising social care across Scotland. I was very clear about that when I went to Shetland. We were really impressed by the level of integration that is being achieved there and the work that is going on between the NHS and the local authority to ensure that a cohesive package of social care is available. I joked with them, saying, "Maybe what we'll do is pick up the Shetland way and roll that out across Scotland; rather than us coming and imposing the Edinburgh way on Shetland, we'll take the Shetland way and roll it out all over Scotland."

However, even in the room at that time, we recognised that, while there are things that Shetland is doing excellently, there are things that it needs national support with. That is where we want to make the difference.

An example is information sharing. A little bit of primary legislation is required to make that easier. When we engage with people with lived experience, we hear that they are tired of telling their stories again and again to everyone whom they meet in the system. The ability to share information safely and appropriately within the system needs to be unlocked centrally, by central Government. We can do that, and it will enable better local delivery.

There are things that we can do to help. Another thing that we talked about was the challenge of recruiting professional social workers in Shetland. There are definitely things that we can do nationally to support that and make it easier to recruit and train by taking away some of the barriers to entry to training that exist in places such as Shetland.

I am keen to hear what the challenges are in every local area and to see what we can do nationally to unlock them. I am not interested in micromanaging from Edinburgh the entirety of social care all over the country. I have said that time and again.

I live in the rural west Highlands. Social care in Ullapool, where I live, looks very different from social care in Inverness, but both are within NHS Highland. Even within local authorities, if they are to be responsive to the needs of their communities, their geographies and the situations that they face in terms of labour shortages, they will have to be flexible in how they deliver. We are keen to create a system that supports that and empowers people while maintaining national standards. There should be a clear expectation that, wherever people are in the country, they know the standards and the quality of services that

they can expect to access, even though services might look a little different, depending on where they are accessed.

The Convener: I thank the Minister for Social Care, Mental Wellbeing and Sport and her officials for attending the meeting and for the information that they have provided.

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

10:26

Meeting suspended.

10:35

On resuming—

Pre-budget Scrutiny 2024-25

The Convener: Our third item is a further evidence session as part of the committee's pre-budget scrutiny for 2024-25. I welcome our witnesses, who are from the Scottish Government: Richard McCallum is the director of health finance and governance; Stephen Lea-Ross is the deputy director of health workforce planning and development; and Niamh O'Connor is the deputy director of the directorate of population health. We move straight to questions, starting with Evelyn Tweed.

Evelyn Tweed: Good morning. My questions are probably for Richard McCallum, but if anybody else wants to come in, please do. Are the financial pressures evenly spread? Might areas that are geographically remote or more deprived experience those issues more acutely? If so, how can that be mitigated?

Richard McCallum (Scottish Government): Thank you for the invitation to speak this morning; we appreciate the chance to come along. The evidence that the committee has heard and some of the written submissions that have come in from other areas have been really useful in informing our budget considerations as we work forward. We will also get the committee's report in due course, which is much appreciated. On Evelyn Tweed's specific question about rurality factors impacting on the cost of services, that has come through in evidence sessions with the likes of NHS Borders.

I will highlight three things. First, there are financial pressures across the whole system. Whether you are in an urban or a rural health board area or in a more remote rural area, those pressures are felt across the system. Increases in inflation, for example, affect all boards. That point should be noted.

Secondly, you are right to say that there are particular challenges for remote and rural boards. There have been challenges around recruitment and retention, in particular, which can drive additional costs.

Thirdly, on what we are doing about that, I will make a couple of specific points. We have talked before at the committee about the NHS Scotland resource allocation committee formula, which is the key and main driver of funding for health boards in Scotland. As well as taking into account factors such as age and deprivation, the NRAC formula takes into account remoteness and rurality; it also takes into account factors that might drive increased costs.

When we allocate to health boards, we actively take account of the NRAC formula, but we also try to take specific actions and make specific investments on top of that. In primary care, for example, we are currently doing remote and rural healthcare work through NES—£3 million will be invested over the course of the next year to support that work, which will help to promote and support retention of services in remote and rural areas.

Evelyn Tweed: How are short-term and long-term needs being balanced? We heard a lot about both in evidence, especially in relation to preventative spend.

Richard McCallum: I will perhaps bring in Niamh O'Connor in a second to talk about some specific examples. The answer is that we have to do both, and the two are not separate. We know that we currently have some acute and specific needs as a result of the backlog of people who are waiting for services, and it is right and important that, as we come to the budget considerations, there is appropriate investment to support our health boards as they tackle those backlogs.

Equally, however, we know that, as you said, the longer-term reality is that we need to get upstream and ensure that we close off at the source some of the pressures that we currently see in our acute hospitals. Work is being done on multidisciplinary teams in a number of boards—we have seen a big increase in that—and we are looking to drive more support and care for people in the community. We are also doing a whole lot more with regard to wider investment—for example, on minimum unit pricing or other things in the alcohol space that are about trying to support very early prevention. Niamh O'Connor can tell you about some more specific actions.

Niamh O'Connor (Scottish Government): Evelyn Tweed is absolutely right. Written submissions to the committee from Public Health Scotland, health and social care partnerships and the Institute for Public Policy Research, as well as evidence in the previous committee session, referred to the Scottish burden of disease. If we look at demographics alone, looking ahead to 2043, we see that there is a forecast 21 per cent increase in the disease burden.

The important point to note from that work is that that is the figure without any impact as a result of prevention or innovation—it looks only at demographics. Prevention and innovation often go together, and without those aspects being embedded at the heart of the long-term reform efforts in both population health and the health and care system, we will struggle to make the progress that is needed.

One of the vehicles is the care and wellbeing approach and, as Audit Scotland mentioned in its submission, we need to be clear about what we mean by prevention and preventative spend. The word "prevention" is often used and can mean different things in different parts of the system. We worked with Public Health Scotland around 12 months ago, and in January a publication was produced on clarity of definitions, and what we mean by the public health approach to prevention and the role of NHS Scotland in that respect. There is obviously a much wider role for other budgets, too.

That work clarifies three big components of what we mean by "prevention". Primary prevention is about stopping health problems arising in the first place; vaccination is a classic example, and the budgets for that are key. Secondary prevention is about finding health problems early and intervening to stop them worsening, to produce better outcomes for people—screening is a good example of that. Finally, there is tertiary prevention, which is about managing established health problems as well as possible, ideally close to home, in order to minimise harms.

Ensuring that there is clarity around that definition system-wide has been really important. We did that work so that we would have national clarity for national cross-Government work on some of the wider determinants of health—the big building blocks. I know that, in its pre-budget scrutiny, the committee will be very much aware of, and alert to, the budgets outside the health and social care budget with regard to their impact on poverty, housing and the other things that we know drive health outcomes.

However, there are also local examples of prevention in action. In the primary space, a lot of work is being done around ensuring that NHS Scotland institutions become proper anchor institutions, with their huge footprint and ability to employ large numbers of people locally. There are also examples of anchors regarding the use of land and assets. Service redesign and service change are also taking place in the tertiary space. That is about shifting the balance of care.

I am happy to give a specific example if members would like to hear it. One example this year has been the community glaucoma service—I am happy to say a little about that.

Evelyn Tweed: Thank you.

The Convener: I call Sandesh Gulhane.

Sandesh Gulhane: Richard McCallum mentioned minimum unit pricing. Can you tell me exactly what benefit we have seen from that, please?

Richard McCallum: That work is still on-going and there will be further discussion about that in the coming months. At the end of June, Public Health Scotland published a report that highlighted that minimum unit pricing in its current form had reduced alcohol sales by 3 per cent. It also said that deaths caused directly by alcohol had reduced by 13.4 per cent and that hospital admissions had decreased by 4.1 per cent. Work and studies on that are on-going. Public Health Scotland cannot be specific, but the estimates that it has put in the report suggest that that is a direct impact of the minimum unit pricing that has been in place.

10:45

Sandesh Gulhane: Thank you for that. I am a bit confused, because what you have just quoted for hospitalisations is not a significant figure—it is an insignificant number, so that cannot be right. You talked about the reduction in deaths, but that, too, is not an accurate figure, is it? Actually, it is a potential reduction in an increase in rate compared to England. It has also been shown that dependent drinkers are continuing to drink. Could you explain how you have got to that figure and said that on the record?

Richard McCallum: Okay. I will bring in Niamh O'Connor, who worked closely with Public Health Scotland, which produced the report that I was quoting from.

Niamh O'Connor: Thank you very much, Dr Gulhane. I am aware that you have already put into the public domain your concerns about the evaluation that Richard McCallum just mentioned. As with all studies based on a robust evidence base or surveys—I am thinking of things such as gross domestic product or inflation figures—although the figures are estimates, there is real transparency around the robustness of the way in which those estimates have been derived. The Public Health Scotland evaluation of MUP had a really robust governance process, the details of which are in the public domain. There is expert opinion from people such as Professor Sir Michael Marmot and Professor Peter Rice, who wrote a letter that was published in *The Lancet* recently, in which they expressed confidence in the robustness of the approach and the methodology.

I know that the member has made very important points about clarity of communication around when things are estimates from studies, and the need to make sure that those are transferred into all products that try to explain the results of in-depth evaluations. There are very valid points around the use of, for example, the word "estimate", and ensuring that that nuance is clear in products such as very brief evaluation findings or news releases. That is a very important point.

To go back to the UK Statistics Authority, its fundamental point was that the findings in that final PHS report had been communicated clearly and impartially. There is confidence in the robustness of that evaluation.

Emma Harper: I have a quick supplementary question. Since minimum unit pricing was introduced, we have also had a pandemic. We have heard that, during the pandemic and during lockdown, there were changes in people's consumption of alcohol. Some folk who drank a lot drank even more, and some folk who drank less drank even less. What are your thoughts on how the pandemic has affected alcohol consumption? Has that skewed any of the minimum unit pricing information that has been brought forward?

Niamh O'Connor: I am happy to come in on that. As the impact of the pandemic is better understood by global experts on alcohol consumption, there is a growing consensus that it had an impact on population-level drinking behaviours, especially among the harmful and hazardous category of drinkers, where there was increased consumption. We see noticeable double-digit increases in alcohol mortality in places such as the United States and Canada, and in other parts of the UK.

There is a growing global consensus that that increase is related to the pandemic, so the importance of the evaluation that we have just spoken about is that the findings on deaths averted are made in a controlled scenario that is based on what would have happened if MUP had not been in place. The findings of the evaluation were on population-level drinking behaviours, given the global pattern of the impact of the pandemic. Without MUP, it is plausible that the mortality rate in Scotland would have been much worse.

I did not respond to Sandesh Gulhane's point about dependent drinkers, and I would like to make an important point about that. If Emma Harper is happy, I will cover that briefly now.

Emma Harper: I am happy for you to do that.

Niamh O'Connor: It is very important to say that dependent drinkers are a small subset. Estimates vary, but potentially around 1 per cent of the population is at the extreme end of the spectrum, which means that they are harmful and hazardous drinkers who have clinical addiction needs that need clinical support.

I know that a number of committee members were part of the cross-party work with the Non-Communicable Disease Alliance on its recently published report, but it is a critical point that

packages of measures are always necessary for complex social outcomes, because there is never a magic bullet, and that is the case for alcohol harm. Prevention is in the primary, secondary and tertiary areas—it is a kind of spectrum—so there are a range of measures around alcohol interventions, UK clinical guidance being updated and the investment going through alcohol and drug partnerships to support improvements in treatment for those suffering from alcohol dependency and addiction. That is a very important point, and the committee has made it well.

Emma Harper: We now have a minister who has a combined portfolio that includes drugs and alcohol, and minimum unit pricing is not the only action that is being taken as a public health approach. You mentioned the Non-Communicable Disease Alliance. I took part in creating its report regarding NCDs.

Tess White: My first question is a nuts-and-bolts one. Richard McCallum, how is the allocation of social care budget agreed within the overall health and social care budget?

Richard McCallum: We have conversations about that with the health sector and local government. We also have conversations with COSLA, which will be involved in the discussions that we will have during the coming weeks and months, as we move closer to the budget period. We will do that in conjunction with wider Scottish Government colleagues and, as I said, with external stakeholders—COSLA, in particular.

The key things that we will consider are the commitments that have been made and shaped in the policy prospectus and the programme for government. As committee members will be aware, one of the key commitments is to increase pay in adult commissioned services in social care to £12 per hour. We will take that into account.

The other factor that we will consider as part of the budget process is the overall allocation to health boards. Health boards allocate a further element to integration authorities, and integration authorities have overall budget responsibility across a range of health and social care services. Therefore, some of the consideration will be about the allocation of funds to IJBs, ultimately.

Tess White: Okay. So, different stakeholders will pull in the data.

My second question relates to a previous committee session in which Philip Whyte, of the Institute for Public Policy Research, said:

"When it comes to staff, funding, resources and everything else, the balance of where we deliver care is still very much stuck in the secondary first model, rather than starting to look at what we can do to bolster the role of primary care."—[*Official Report, Health, Social Care and Sport Committee*, 19 September 2023; c 3]

Is that a fair assessment, in your opinion? Has primary care been given the funding that it needs?

Richard McCallum: This point has probably been considered, including by this committee, for some time. We talked about the shift in the balance of spend from secondary acute care to community primary care and Scottish Government ministers' commitment to shift that beyond 50 per cent over the current parliamentary session. We are just short of that, at around 49.2 per cent. Making that shift happen will be a key consideration in this budget and future budgets. So, at a strategic level, there is a key focus on moving spend.

There is a key commitment from ministers on that increase in primary care funding. Let us take the primary care improvement fund as an example. It has grown from £155 million a couple of years ago to £170 million a year ago and £190 million in the current financial year. A key consideration for us, because it is a fair challenge of out-patient primary care, is the need for that to increase further.

Good evidence is coming through on our work on multidisciplinary teams and community link workers, which is having a real impact. That is certainly part of the budget consideration, and some of the evidence that you have already received will be a big part of our considerations. Does either of my colleagues want to say any more on that point?

Niamh O'Connor: I am happy to come in with a specific example if the member would find that useful. We sometimes talk about shifting the balance of care in an abstract way, but I mentioned the community glaucoma service in the example of tertiary prevention and managing a condition as well as possible, and ideally close to home. That service has now been rolled out after a good number of years of work with community optometry, the ophthalmology profession and patients who receive the service. NHS Greater Glasgow and Clyde first sent letters out to patients. The service discharges clinically appropriate patients with glaucoma from the hospitalised service to management in the community. That is care closer to home. It is a concrete example of shifting the balance of care with appropriate work with our national boards, including NES, on the workforce developments that are required.

At its full roll-out, the service should be able to see up to 20,000 patients. NHS Lanarkshire is next to roll out, in November. We know that ophthalmology is often one of the busiest out-patient specialties. Philip Whyte, whom Tess

White mentioned, referred in his evidence to specific examples of shifting the balance of care.

Tess White: That all sounds good, but, last year, the Scottish Government cut £65 million from the primary care budget, which is a huge amount of money. How is primary care meant to cope with increasing demands when services are being cut like that?

Richard McCallum: I will say a couple of things on that. I think that you refer to the emergency budget revision that happened in November last year. That budget decision was taken in the context of a very challenging financial settlement across the Scottish Government, and all portfolios faced a financial challenge. That was a non-recurring production; it has not continued indefinitely. Although that pressure was recognised as part of the 2022-23 financial position, that £65 million revision will not recur.

As we have built up additional funding in primary care over a number of years, some of the money that has been allocated is in IJB reserves. There was an expectation that, rather than allocate additional funding to support things such as the primary care improvement fund, the integration authorities would use their reserves in the first instance, before additional funding was allocated.

That was the decision on the £65 million, which, as I have said, has not rolled forward into the current financial year. As you said, we know that primary care is incredibly important as we move forward, so we will consider that as part of the 2024-25 budget.

11:00

Gillian Mackay: Many submissions to the committee have highlighted the difficulty of engaging in forward planning and prevention while relying on single-year funding settlements that may be linked to evidence of performance in the short term. How is the Government working with health boards to support them to engage in long-term financial planning? How likely is it that we can move to a system of multiyear budgeting, given that many of the Scottish Government's budgetary decisions rely on those of the UK Government?

Richard McCallum: That is a fair challenge, and I know that a number of boards and others have raised that issue with the committee.

There are two fundamental points in relation to that, one of which Ms Mackay picked up on. First, we are in a cycle of largely single-year budgets. Ultimately, money is allocated to us, as a Government, on a Barnett formula basis by the UK Government and it is quite difficult to plan ahead when there is uncertainty beyond the current year. That is not to say that we do not work closely with the Treasury and the Department of Health and Social Care at the UK Government level to understand expectations and plans. However, in a formal sense, even the budget this year will come after the autumn statement at Westminster. We work in that environment. Even over the past couple of years, with some of the general uncertainties that we have seen around Covid money, pay and other things, planning has been quite difficult, but we do it.

Secondly, multiyear budgeting would absolutely help, but we have tried to give health boards and integration authorities—we work very closely with health boards and integration authorities on this—some planning assumptions for future years. We have already mentioned the drugs budget, and there was a commitment to a £250 million investment over the lifetime of the Parliament. Boards, IJBs and other partners should be working on that basis. There is no expectation that we will stray from that; if anything, we would consider putting more investment into that. We have done that across a number of areas. We have mentioned mental health and primary care, as well as some of the planned care investment.

There is that challenge, but we try to give health boards and integration authorities as many planning parameters as possible in that context.

Gillian Mackay: That is great. Thank you.

Data is a bugbear of mine—particularly how it informs budgets and outcomes. How can data collection be improved to ensure that it is not only sufficient to measure performance but is linked to long-term outcomes and therefore informs budgets and other things going forward?

Richard McCallum: Niamh O'Connor might want to come in on some of the specifics.

I hope that, at a strategic level, there is evidence and information that supports all our budget decisions. I will take something as specific as some of the planned care investment that has been made over the past couple of years, as that is considered as part of this budget. We will want to be absolutely clear about what we expect boards to deliver and about the improvements and outputs, in line with the trajectories that the cabinet secretary set out in the programme for government and the mandate letter. Maybe they are more outputs than outcomes, but we would want to be absolutely clear about that.

Niamh O'Connor mentioned the example of the multidisciplinary teams. We are starting to build up some strong evidence about the difference that those teams are making across primary care and mental health, as well as in other areas. You are absolutely right: as we work through this—again, it is something that we will be doing in conjunction

with stakeholders—it is absolutely key that we draw on that data and that we base our budget investment decisions on where we are seeing real impact and change.

Given that she works closely with Public Health Scotland, Niamh O'Connor might want to say something about its input into some of this.

Niamh O'Connor: I am happy to say something briefly, if the member is content for me to do so.

I know that the committee has been concerned about the multiplicity of outcomes, frameworks and other ways of understanding change. What is important in that respect is, I guess, to understand which data to go to for what purpose. Where we need to, say, track investment or activity—that is, inputs into the system—there will be things such as previous local delivery plan standards and so on. I think that the committee member was asking about outcomes, so the question really is, how do we know that we are making a difference with regard to the outcomes that we are seeking?

As the public body that is the expert on prevention as well as the expert on data and analysis, Public Health Scotland is carrying out work that, I should point out, does not seek to duplicate something like the national performance framework but instead seeks to clarify what we know drives health inequalities and the measures around those—for example, the early years, good work, good income and our outcome indicators around all of that. It is learning from the experience from Covid, too, and it is working with the Improvement Service on dashboards that will be useful locally in community planning when people organise efforts to address, on a local basis, health inequalities and health outcomes. That care and wellbeing dashboard, as it is called, was launched in June, and it is what we are using to track progress on the overall outcomes. Evaluation is the key link between the data on our interventions and our activities, the data on the outcomes and what is plausibly driving both—either whatever lies within the gift of the Scottish Government as a whole or, indeed, wider factors, of which there have been a number in the past decade.

The Convener: I call Carol Mochan.

Carol Mochan: Thank you very much, convener.

My question probably links with what has just been said, but I am interested in finding out whether and how the Scottish Government tracks spending by each NHS board on its current policy priorities.

Richard McCallum: I will bring in Niamh O'Connor in a second to give you a couple of specifics. In a general sense, we work through our policy teams within Government. On specific commitments on, say, mental health, alcohol or drugs, we work very closely with our boards and IJBs to ensure that information is returned to us to provide clarity, not just on spend but, crucially—as you have said—on the investment that is being made and whether early outcomes are being seen.

At a data level—again, this speaks to the work that Public Health Scotland does—we have a cost book that essentially annually translates the budget and what the Scottish Government has invested, and tracks how that investment has been spent by our health boards. It starts to give us a good picture of things. There is a time lag—we do not get the information until a few months after the year end—but it still gives us a good sense of whether, in the areas on which we are focusing our investment, which we have already mentioned, and where we are looking to see more investment in the community, things are being borne out in reality. The past two to three years have been difficult and things have probably been skewed somewhat because of the challenge of the pandemic. Nevertheless, we are building evidence and data back up in the cost book, and that is certainly something that we will be looking to build on as we move forward.

Do you want to add anything, Niamh?

Niamh O'Connor: I can briefly add something.

Richard McCallum has just talked about tracking investment. The member asked about outcomes by board against, for example, the commitments in the prospectus. The dashboard that Public Health Scotland has launched, and which I have just mentioned, contains all the data to provide evidence on what we know influences health and health outcomes. That data is available by health board area and can therefore be broken down. The dashboard is still at an early stage and information is still being added to it; however, where data is available by local authority area, work is taking place to make that breakdown available, too. That is just one element of how outcomes are being tracked by geography.

Secondly, I want to amplify one of Richard McCallum's points. Investment in prevention is critical—not least investment outwith the health and social care budget, such as the very big investments in the Scottish child payment. However, when we look back over the past 20 years at some of the things that have made the biggest difference in public health—in preventing ill health and in making improvements in mortality in relation to cardiovascular disease, for example—we see that legislation has had an important role, too. For example, there have been non-fiscal interventions such as the smoking ban in 2006 and a package of other measures, over

time. That issue was mentioned in the written submission from PHS.

I hope that that is helpful.

Carol Mochan: It is. To come back on that a little, I note that sometimes—particularly with big spends—it can be hard to see where money has been moved about. Could we record anything differently, or better, to enable scrutiny and ensure transparency on where money actually goes once it is in the system?

Richard McCallum: In the budget, for example, the committee will rightly often see that broken down into large spend areas—planned care or others—and then broken down by health board, but you do not necessarily get the detail or data on how it is subsequently spent. I mentioned the cost book, which is critical to seeing whether the budget that we have set translates through into spending that is, ultimately, undertaken by health boards and others.

We want to do more on that issue—we are doing more on it—as we move forward, on some of the key investment areas that we have talked about. We would welcome the opportunity to come back to the committee on the issue and to give you that data, because it is important and helpful for you to see it, as well.

Carol Mochan: There have been advances in relation to mental health budgets, which we can see more clearly. As you said, there is scope to look at other areas, which would be helpful for members and for the committee as a whole. Thank you.

Sandesh Gulhane: My question is similar to Carol Mochan's. Do you feel that we have enough transparency in the way that taxpayers' money is spent, and do we have the ability to really track it so that we know where all the money is going?

Richard McCallum: The investment that we put in the health and social care system is no secret. If you, as a committee, feel that there is information that you are not seeing, or you would like more information, I would be pleased to give you it. It is absolutely crucial that you can see it, and that you can hold us to account on it.

In answer to the question, I say yes—I think that we have good information in the cost data that we have, but we can always improve it. I see the information at two levels, in particular—health board and IJB levels. It is absolutely important that local communities have a clear sense of where boards and integration authorities are investing their spend. We get annual reports from integration authorities and health boards, which set that out and give that detail at least annually, which gives a sense of how the money that has been allocated to those areas has been used. That is critically important.

Similarly, I have mentioned the cost book and the data on overall spend at national level. The Government has asked integration authorities in particular to detail how they have used particular funding streams. Ms Mochan mentioned mental health, but there are other areas for which we have that information and are pulling through the data. However, if we can do more to give the committee that information or make it public, we would be happy to do that, because it is absolutely important that we are transparent in tracking spend.

11:15

Sandesh Gulhane: Thank you. In previous evidence sessions, we have been told that it is very difficult to track how money is being spent and where it is going. I asked the question because it is important that we are able to define transparently and clearly where taxpayers' money is going. Given your answer, do you feel that you can track all the money that is being spent and exactly where it is going?

Richard McCallum: It is a huge budget, obviously, and investment is made in many areas and priorities across health and social care. However, as I said, at a local level, health boards and IJBs can provide a lot of that data and information; indeed, they are already doing that in their annual reports. We follow up and track all investment.

I will go back to Ms Mackay's earlier question. One of the key things—especially given the financial constraints that we have and are likely to see over the next few years—is that we must be confident that our investments are making the differences that we want them to make.

There can be challenges, including in getting that information back in a timely way. To go back to your earlier question, I note that we want to ensure that all the information is accurate. However, there is a clear way that we can and will track that spend. We absolutely can track spend on the specific policy areas that we have picked up on today. As I said, I am more than happy to provide as much of that information to the committee as you would find helpful.

Sandesh Gulhane: Thank you.

I declare my interest as a practising NHS GP.

Stephanie Callaghan: Many of my questions have been answered or touched on. We have heard about the care and wellbeing dashboard. We hear a lot that short-term targets can drive decision making, but I am interested in longer-term

objectives. What can we do to encourage setting of budgets with that in mind?

Richard McCallum: Niamh O'Connor might want to say a bit more about the care and wellbeing portfolio and the work that is being taken forward there. The starting point is that the programme for government and the mandate letter that was issued a month or so ago will be the primary consideration and drivers in our budget considerations. The cabinet secretary has been absolutely clear that it is about recovery and reform and holding those two things together.

There are certain immediate pressures in secondary care, and there are immediate pressures in planned and unscheduled care. If additional investment in those can be effective, we should look at the options to take that forward. Investment in things such as the hospital at home service has absolutely supported our doing that.

However, the point is that I see that not only as a short-term investment. We hope that hospital at home will have an impact this winter and will help with the unscheduled care challenges that we will undoubtedly face, but it is also a long-term solution. The outcomes from care and treatment at home are good, and better, for the people who receive that service. Therefore, we recognise that there is a balance to be struck, in that there is short-term investment that we also see playing out with the longer term in mind.

The reform element is absolutely key. We are using the care and wellbeing portfolio as an example, which the committee has received evidence on before; I think that it was discussed at the PFG session with the cabinet secretary. It will be a key mechanism for driving forward some of the reform that you mention.

Niamh—do you want to pick up on anything specific?

Stephanie Callaghan: Could I ask you, Niamh, to touch on keeping people's experiences at the centre, as well?

Niamh O'Connor: Yes, absolutely.

The point of the care and wellbeing portfolio is for it to be the long-term reform place for population health in relation to the big risk behaviours that we have spoken about reducing, and for service and whole-system reform, including in wider government. The £3 billion investment in tackling poverty, for example, is absolutely critical in relation to benefits and the building blocks of health.

The long-term point of the portfolio is to bring all the reforms together in one place. Besides the service reform and population-health measures that we have spoken about, there is work being done on areas such as innovation, digital and analysis—on building those capabilities in Scotland so that we are best able to deal with long-term challenges.

One of the other big cross-cutting areas is co-design, service design and engagement. The committee might already have heard about some of the summer design events on national care service development. Part of that has been the establishment of a lived-experience expert panel. When we speak to people, we know that they do not live policy-siloed lives. If they are speaking about their experience of social care, it will often extend to their experiences of local healthcare services. That information is all being gathered together and used to inform the thinking on long-term reform and developing the building block of constant public engagement that we need in order to reform services for the long term.

Stephanie Callaghan: That leads on to my next question. How can the interdependencies between various spending areas be better taken into account when making budget systems and looking at performance frameworks?

Richard McCallum: I will take that first.

I will make a couple of points. Niamh O'Connor touched on how, when we talk about some aspects of primary prevention, a lot of the spend is well outside the health and social care portfolio. As we move forward with this and subsequent budgets, having a real and clear connection across areas will be key—across education, justice, housing and local government, for example. It is a whole system and a whole package, so there is consideration in a number of areas.

We are doing a lot within the portfolio but, no doubt, there is more that we could do. We have talked about primary care as being the place where most interactions in our health and social care system—certainly in our healthcare system—happen. Work that has been done on multidisciplinary teams and community link workers, which we have touched on, is making a real impact in relation to investment in mental health and other conditions. We are starting to build that up. We are not seeing the siloed approach within our portfolio; we are trying to make sure that our investment is coming together through the portfolio, as Niamh mentioned, so that we are making the best funding decisions and making sure that it reaches people in the best way possible.

Niamh O'Connor: I can add a specific example, if Stephanie Callaghan would find that useful.

Stephanie Callaghan: Certainly.

Niamh O'Connor: We spoke a little about benefits and things such as the Scottish child

payment and the impact on the building block of addressing poverty. Obviously, benefits' impact on preventing ill health is felt only if individuals claim, or can access, the benefits that they are entitled to, so a lot of work is being done in relation to interdependencies between NHS services and wider services, in order to ensure income maximisation.

A recent example is NHS Lothian's having established income maximisation services across every hospital in the NHS Lothian estate. The board is starting to gather management information on that and, in the nine months to June this year, more than 700 patients who were often at vulnerable points in their lives, when they were accessing healthcare, got the benefit of the income maximisation service. That is a whole-system change that has been funded partly by NHS Lothian Charity, and managed and overseen by the public health experts in NHS Lothian.

From the management information, we can see that the confirmed financial gain was around £400,000 just in that nine-month period. The solution is, therefore, to have a combination of national interdependencies and local action. As I said, the impact on preventing ill health is experienced only where households have the benefit of national policy changes and measures such as the Scottish child payment.

Stephanie Callaghan: That is a great example. Thank you very much.

Paul Sweeney: I thank the witnesses for their contributions so far. I want to turn to health and social care outcomes. Many written submissions to the committee have noted that the short-term nature of national targets is impacting on clinical priorities for investment. Decisions are often made to satisfy expectations in the short term, as opposed to the long-term impact of patient investment being measured. What are the panel's views on alternative measures for monitoring performance that would allow for longer-term planning and more rational decision making on investments?

Richard McCallum: That is a consideration for ministers, in the first instance. As for investment decisions, or the choices that we are making, I do not see this as an either/or situation. The more immediate standards and improvements that we want to see are referenced in, for example, the programme for government. That is absolutely right, and it is the expectation of the population, so we ensure that those are factored into our investment decisions.

However, it is key that we have an eye on the longer term and do not make short-term financial decisions just to meet immediate pressures. The medication-assisted treatment standards that form part of the national drugs mission are an important example of that combination approach of wanting improvement in the short term and seeing the need to address the longer-term challenges. I think that we can build up more activity in that area.

Public Health Scotland's work on examining data over a longer period will help to inform our longer-term targets. On our budget choices, it is about finding the right balance between immediate service needs and the longer-term focus. [*Interruption*.]

The Convener: Have you a further question, Mr Sweeney?

Paul Sweeney: Yes. Sorry about the delay; I was waiting for my microphone to be unmuted.

That point is fairly made. However, I recently met GPs in Glasgow who said that they are so focused on dealing with immediate clinical requirements, which are overwhelming, that it is just not feasible for them to have any head space or time to consider continuous or process improvement with their teams in practice. There is not the capacity or the space to undertake such activity.

That really goes to the core of the tension between short-term firefighting and longer-term continuous improvement. The biggest commodity in the NHS is, of course, time. How can we move the NHS, as what we might call a learning organisation, away from such firefighting and being in crisis mode into creating a space for continuous improvement and for workstreams that can help to drive activity? For example, is there an account management service, or do you bring in specialisms from other industries? For instance, many economists say that we should look to the aerospace industry for good examples on how to drive productivity.

The NHS is the single largest employer in Scotland so its approach will have an impact on our national performance. How can we move to getting the everyday economy in areas such as the NHS mobilised in the same way? How can we bring a culture of productivity improvement into the service? Have you ideas for how that could be achieved?

11:30

Richard McCallum: That is a really fair challenge. As the committee will know, the reality is that, after two or three years during which a lot of our services were, for understandable reasons, scaled back or curtailed, we have a backlog and there is real challenge in the media, so that investment is really important.

I will bring in Stephen Lea-Ross in a second to talk about some of our work with system leaders to look at the question about developing our staff, leadership and productivity.

The primary care point that you raised, Mr Sweeney, is a challenge. The investment that has been made in multidisciplinary teams—the number of staff working in MDTs has grown to more than 4,500—will, I think, have an impact. It is something that we are looking at for the future.

In terms of the pressure that GPs are facing, and in relation to the example that you highlighted, we hope that MDTs will have an impact on that and assist GPs as we move forward. Clearly, phase 2 of the contract will be a key part of it. I know that you have evidence-taking sessions with primary care colleagues coming up. I am sure that they would be happy to expand on some of those points.

Your point about productivity is right in that that is partly about the money that we invest. However, it is also about making sure that we get the best value for the money that we invest and ensuring that our system is as productive as possible, while recognising that, in many instances, our staff have been through some significant challenges over the past couple of years. It is about holding that balance in line.

Steve, do you want to talk about some of the work that we have done with our staff to support them?

Stephen Lea-Ross (Scottish Government): Yes, I am happy to do so. I will make a couple of broad strategic points, then perhaps give a couple of examples in response to the overarching question on productivity.

One of the things that we have tried to do through framing the new national health and social care workforce strategy, which we published in March 2022, is to draw out the relationship between recruitment, staff development and training and the infrastructure, technology and tools that staff use to do their jobs. Part of what we are now trying to embed through the workforce strategy implementation programme is the drawing out of the links in that relationship, particularly between where staff are working and how staff are working in terms of their relationship between one team and another and their access to tools and equipment.

In addition, to pick up Richard McCallum's point about encouraging whole-system recovery after the acute phase of the pandemic, we have invested quite significantly—this is set out in the strategy—in physical and psychological supports for staff, not only to encourage attendance but to allow them to reset and rebalance themselves following the pandemic.

Richard McCallum has already picked up the point about the growth in staffing in MDTs, and we can see through the national monitoring and evaluation strategy for primary care and through some locality-based evidence where that is already having an impact on releasing GP time by embedding additional physiotherapy support, community link worker support and pharmacotherapy support. That is also demonstrating a more efficient use of resources with better patient outcomes, particularly in relation to pharmacotherapy examples.

We have looked at our approach to planned care recovery, staffing and productivity. In partnership with the Centre for Sustainable Delivery, we have looked at a range of interventions that try to increase the productive opportunity in those centres without meaning that—I have to stress this—staff have to work more hours or do more work. It is about aligning the whole of the system end to end and looking at the productive capacity across the whole of our estate in NHS Scotland.

Through the national elective co-ordination unit, for instance, we have managed to use what was previously a little fallow capacity in certain theatres throughout the country, delivering about 3,500 additional elective procedures so far this year. We have also been looking at the structuring of teams and workforce diversification in that area, in particular to improve productivity progressively without increasing the direct burden on staff in front-line services.

Paul Sweeney: Thank you for that. Do you feel that lean improvement—continuous improvement—is very much driven from the ground up, and that it is often the innovators on the front line who have the best insights on what we need to do to improve productivity and efficiency?

With that in mind, do you feel that we could do more on continuing professional development, even looking across to different Scottish Government agencies, such as Scottish Enterprise and the Scottish manufacturing advisory service, to teach tools and techniques that could allow more practitioners in the national health service to identify opportunities where there is waste and where efficiencies could be achieved? In that way, we could start to develop those ideas organically and move them forward.

Richard McCallum: I will come in on that first—Stephen Lea-Ross might want to add a couple of things.

I will give an example. You are right—it is often our staff who have good ideas for how we can improve our work. A specific example is climate. The national green theatres work that we are

taking forward has been clinician led. Clinicians, in particular in NHS Highland, have come together not only to identify monetary and productive efficiencies but to do work on, for example, anaesthetic gases and waste separation. That has not been the result of an edict from on high, albeit that we are very focused on the on-going work on sustainability—the theatres project was led by teams in the system. You are right to highlight that how we harness that will be key as we move forward, because the best innovative ideas often come from the front line.

That said, there is also wider harnessing. You mentioned Scottish Enterprise, for example. Across our innovation landscape, we are doing a lot of work with colleagues in Scottish Enterprise and in the Scottish Government economy directorate on the research projects that we have under way. We have seen real benefits coming through from that—for example, from the work on closed-loop systems for diabetes and on theatre scheduling. A lot of innovative work can be done. We need to ensure that we invest in that and that people have the time to focus on it; however, given the challenges that we face, it is right that we drive that forward.

I do not know whether Stephen Lea-Ross wants to add anything.

Stephen Lea-Ross: I will give a couple of other practical examples. Again, through our work on elective recovery, we took a bottom-up approach to developing staffing models directly with theatre teams across the national treatment centres that have opened or are in the process of opening this year, in particular in NHS Highland and NHS Fife, and with NHS Golden Jubilee National Hospital.

We invited clinical staff themselves to challenge assumptions around the staffing model and the staffing mix; to engage with the challenges that exist in the wider economy with regard to attracting particular groups of staff; and to look at what alternative staffing solutions there might be. That led to positive change on rethinking the mix, in particular in the centre in Inverness, and rebalancing the number of registrants with support staff. That work begins to feed into a pipeline when it is tied together with the work that is being done around anchors and future development.

That said, there will have to be an increased focus on the productive capacity and opportunity that might come through future technological innovation with regard to both how our staff work and the tools that they have to do their jobs.

Again, that is something that we have framed in outline in the national workforce strategy. There is further work to do on scoping where we might be in the next five to 10 years. Quite a lot is being done in the context of the innovation design authority on how artificial intelligence can support imaging staff. AI can support the administration of staffing and how staff are rostered and used throughout the system. Some systems innovation is being driven by the wider landscape that we are looking to embed as part of the overall approach to balancing staffing, productivity and service need.

The Convener: We have limited time left, but we have quite a few questions still to ask. I ask everyone to be brief and I will have to practise what I preach. I declare an interest as a registered mental health nurse.

I am keen to move on to the topic of workforce and pay. How can the twin pressures of increased pay and demands for additional staff in the NHS and social care be balanced within the limited resources of the Scottish Government budget and its limited borrowing powers? That might be one for Stephen Lea-Ross.

Stephen Lea-Ross: At the outset this year, we took a clear overall strategic approach in reaching the pay settlements, both for agenda for change staff and for doctors and dentists. We sought to reach a fair, proportionate and reasonable settlement in the context of the wider economic circumstances and to proactively minimise the disruption that would have occurred had there been a breakdown in industrial relations.

There are two points about the balance. I will try to be as brief as possible. Looking ahead, we have to look at the totality of terms and conditions. Although we have made the investments over the course of the year and pay will continue to be determined through that tripartite process directly with unions, we are looking at the balance of investment in pay going forward with progressive terms and conditions reform. When we look at international benchmarks for careers in health and social care, it is the total package that makes them attractive. In the context of present-day shortages in health and social care personnel, retention is as important—if not more important, given the acute pressures—than investment in recruitment. That is not to say that we should spend on one rather than the other, but we have to take those strategic decisions in view of the total economic context in which we are operating.

The Convener: Thank you for your brevity in that complex answer.

Emma Harper: I will be quick because a lot of information has been covered already. In our previous evidence session, the witnesses talked a lot about whole-system approaches to the budget. We know that we need to tackle poverty and health inequalities and the impact of housing on those—there are loads of umbrellas that are needed to support the improvement of the health

of the people of Scotland. I am interested in public health and preventative approaches. I am interested in the ability to have a good healthy diet, for example. I am interested in the work of Henry Dimbleby and Chris van Tulleken, as well as Professor Pekka Puska's work to improve diet to reduce cardiovascular disease. What work is being done to learn from other researchers who are not even in Scotland, to see how we can budget better for public health measures?

Richard McCallum: Niamh O'Connor will be able to give some of the specifics on that.

You are right—it all comes back to evidence-based budgeting. That is what we are seeking to do on a global as well as a granular scale. We talk about diet and obesity and the investment that we are putting into that. Key for us when the policy teams consider the issues and we make those investment decisions is what the international evidence shows us and how we can evaluate that as effectively as possible so that our investment really maximises our contribution.

I know that we are short of time, but Niamh might want to add something more specific.

11:45

Niamh O'Connor: I will be brief. It is exactly as members of the committee said in relation to the NCD Alliance report; it is about the whole package of measures and learning from other systems. We need to think about the criticality of early years, the Heckman curve and return on investment; all that is part of the nutrition policy landscape, as are free vitamins for under-threes and breastfeeding mothers. The whole-system approach to diet and healthy weight has to start at the earliest opportunity, and it has to include the whole package of legislative and fiscal measures.

When the Minister for Public Health and Women's Health was here for the programme for government evidence session recently, she signposted the next steps on trying to restrict promotions of foods that are high in fat, sugars and salt, which has a strong overlap with some of the Dimbleby concerns that you mentioned. There is active work on bringing that forward as soon as possible.

Emma Harper: The Institute for Fiscal Studies has published an interesting report on short-term, medium-term and long-term planning. It focuses on the fact that the Scottish Government's health budget depends on Barnett consequentials, so it is determined by the UK Government. If we do not know what is coming from the UK Government, does that pose challenges in determining what needs to be incorporated into preventative health planning or acute planning?

Richard McCallum: That loops back to Ms Mackay's question. In general, we get the consequentials annually, albeit that we are making some assumptions about future years. Once the total Scottish Government budget comes, ministers can choose to use it how they wish, but, if we were to put even more into health, it would be at the expense of other portfolios that have equally pressing needs.

In the past year, funds in excess of consequentials have been put towards the health and social care budget, so it is a challenge that needs to be worked through. In that context, we are trying to ensure that we have a clear financial framework that we can use to make the decisions that will impact us over the next five to 10 years.

The Convener: Paul Sweeney has a final brief supplementary question.

Paul Sweeney: I am intrigued about practical realities. How do you pivot the healthcare system from current acute spend in hospitals towards preventative spend in communities? We spend more on acute hospitals than any other healthcare system in the developed world does. How do we shift the balance practically?

Richard McCallum: That links to a lot of what we have said. It is partly about building on the up-front investment that we have made in preventative areas, which will need to continue. I do not necessarily see it as an either/or situation. It is important that we continue to invest in our secondary care services and make sure that the funding is available when we need it. That will partly happen through deliberate budget choices, but not only through budget choices. Policy choices that do not necessarily come with huge financial costs will help to shift the narrative and the service delivery.

The Convener: I thank witnesses for their attendance this morning, and for the evidence that they have given to the committee. At our next meeting on 24 October, we plan to take further evidence on the National Care Service (Scotland) Bill. That concludes the public part of our meeting.

11:49

Meeting continued in private until 12:26.

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