OFFICIAL REPORT
AITHISG OIFIGEIL

# Health, Social Care and Sport Committee

**Tuesday 16 January 2024**

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

# Tuesday 16 January 2024

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## HEALTH, SOCIAL CARE AND SPORT COMMITTEE

**1st Meeting 2024, Session 6**

**CONVENER**

*Clare Haughey (Rutherglen) (SNP)

**DEPUTY CONVENER**

*Paul Sweeney (Glasgow) (Lab)

**COMMITTEE MEMBERS**

*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Ruth Maguire (Cunninghame South) (SNP)
*Ivan McKee (Glasgow Provan) (SNP)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Tess White (North East Scotland) (Con)

*attended

**THE FOLLOWING ALSO PARTICIPATED:**

Michael Matheson (Cabinet Secretary for NHS Recovery, Health and Social Care)
Richard McCallum (Scottish Government)
Nigel Robinson (Scottish Government)
Scott Wood (Scottish Government)

**CLERK TO THE COMMITTEE**

Alex Bruce

**LOCATION**

The Sir Alexander Fleming Room (CR3)

# Scottish Parliament

## Health, Social Care and Sport Committee

*Tuesday 16 January 2024*

*[The Convener opened the meeting at 09:15]*

## Decision on Taking Business in Private

**The Convener (Clare Haughey):** Good morning, and welcome to the first meeting in 2024 of the Health, Social Care and Sport Committee. I have received no apologies for today's meeting. The first item on our agenda is a decision on whether to take items 5, 6, 7 and 8 in private and a decision on whether to consider in private at future meetings a draft report on the National Care Service (Scotland) Bill. Do members agree to take those items in private?

**Members** *indicated agreement.*

## Budget Scrutiny 2024-25

09:16

**The Convener:** The second item on our agenda is the consideration of evidence from the Cabinet Secretary for NHS Recovery, Health and Social Care, Michael Matheson, as part of the committee's scrutiny of the Scottish Government's 2024-25 budget. I welcome to the meeting Michael Matheson and Richard McCallum, who is the director of health and social care finance, digital and governance at the Scottish Government. I invite the cabinet secretary to make a brief opening statement.

**The Cabinet Secretary for NHS Recovery, Health and Social Care (Michael Matheson):** Good morning, convener, and thank you for the invitation to discuss the Scottish budget and what it means for Scotland's health and social care services. The budget includes funding of more than £19.5 billion for the continued recovery of the national health service—our health and social care system. The budget provides an uplift that exceeds front-line Barnett consequentials. It means that resource funding for health and social care has more than doubled since 2006-07.

Despite that investment, the system is under extreme pressure as a result of the on-going impacts of Covid, Barnett, Brexit and inflation, and United Kingdom Government spending decisions have also resulted in hard choices, as greater efficiencies and savings will need to be made. However, investing in Scotland's NHS is non-negotiable for this Government. The budget settlement gives our NHS a real-terms uplift in the face of UK Government austerity. Crucially, it includes more than £14.2 billion for our NHS boards, with an additional investment of more than half a billion pounds.

The budget supports investment in excess of £10 billion for the NHS pay bill, rewarding our dedicated and skilled NHS staff for their work in recent years. There is more than £2 billion for social care and integration, which means that, two years ahead of our original target, we are delivering on our programme for government commitment to increase social care spending by 25 per cent over this parliamentary session. It provides an additional £230 million to support delivery of the pay uplift to a minimum of £12 per hour for adult social care workers in the third and private sectors from April 2024, representing a 10.1 per cent increase for all eligible workers.

We continue to invest in quality community health services to support our prevention and early intervention priorities. That includes investment of more than £2.1 billion for primary care and

supporting spending in excess of £1.3 billion for mental health.

We will continue to work with partners to address the challenges that the settlement brings and to take forward the reform that is essential for the delivery of a sustainable health and social care system as well as high-quality services. I am happy to respond to any questions that members have.

**The Convener:** Thank you, cabinet secretary. We move straight to questions from members.

**Sandesh Gulhane (Glasgow) (Con):** I declare an interest as a practising NHS general practitioner. Good morning, cabinet secretary, and thank you for coming today.

**Michael Matheson:** Good morning.

**Sandesh Gulhane:** From your opening statement and from what we have heard and seen you say previously, do you feel that you have adequately resourced the Scottish NHS?

**Michael Matheson:** I do not think that you would ever get a cabinet secretary for health to say that they would not want more resource to invest in the health and social care system. In the light of our very challenging budget settlement, we have achieved the best possible outcome that we can for the health and social care budget.

Notwithstanding that, efficiencies and savings will have to be made for us to live within the budget settlement that we have and the growing demand that we face. I think that this is the best outcome that we can achieve in challenging financial circumstances; however, there will be continued challenges for the health and social care system even with this budget.

**Sandesh Gulhane:** What are your top three priorities with the budget that you have set out? What are the three things that you would want and expect at the end of this year and as we go into the next year?

**Michael Matheson:** One is continued investment in our NHS recovery, including in prevention, with a particular focus on primary care. Another is continued investment in mental health services, to ensure that they meet the needs of citizens across the country. Another is continued investment in social care, to ensure that we are doing everything that we can to give it greater resilience, particularly by way of recruitment into the workforce, which is critical to supporting our NHS.

**Sandesh Gulhane:** In laying out those three priorities and in your opening statement, you spoke about mental health. Is it not true to say, though, that there is a 1.6 per cent real-terms reduction in your budget for mental health services?

**Michael Matheson:** The reality is that about £1.3 billion is invested in mental health services. About £290 million of that is central funding from the Scottish Government, and that has increased—in fact, it has doubled since 2020-21. Over the course of the past two to three years alone, we have doubled the level of that investment and maintained it, despite the difficult financial environment in which we are operating. That has allowed a very significant expansion of mental health services in Scotland, and we want to sustain and maintain that. Over the course of the past couple of years, there has been a huge increase in the level of investment that we are putting into mental health services.

**Sandesh Gulhane:** We have seen a significant reduction in mental health across our country. We have also seen significant increases in waiting times for child and adolescent mental health services; the longest wait in Glasgow was 37 weeks to be seen. The reduction in budget will surely impact and harm mental health.

**Michael Matheson:** I disagree with that, and it would be unfair to suggest that waiting times for CAMHS have not been reduced. There has been a very significant reduction in waiting times for CAMHS, and in particular of the build-up that developed over the course of the pandemic. Staff across our child and adolescent mental health services are working really hard to address the waits, and we have seen very significant reductions in them. Of course, where there continue to be extended waits, that is not acceptable, and that is why work is still being undertaken to address the issue.

However, anyone who looks at the course of the mental health budget over the past couple of years cannot avoid seeing that the budget has, in some cases, more than doubled. That has allowed for a significant expansion of services and an increase in capacity of those services, which we are now seeing the benefits of in terms of the waiting-time reductions that we are achieving in CAMHS services overall.

I recognise that challenges remain in delivery of mental health services. Notwithstanding that, very good progress is being made, and the sustained increase in investment that we have made over the past couple of years is making a difference.

**Sandesh Gulhane:** In stating your top three priorities, you spoke about NHS recovery, which you mentioned in your opening statement as well. You feel that you have put a budget for that in place. Therefore, at next year's budget time, should we expect to see significant reductions in improvement in accident and emergency waiting

times and significant improvements in waiting times for procedures?

**Michael Matheson:** Let us look at where we are with A and E at present. We have seen an improvement this year compared with where we were last year. We are continuing to work with health boards to sustain further improvements.

You will be aware that one of the major challenges that we have with A and E performance is flow from A and E into hospitals. A significant part of that is caused by delayed discharge. Despite the fact that around 98 per cent of all discharges from hospital take place on time, the 2 per cent that do not have a significant impact on flow into hospitals from our A and E departments. This year, we saw a reduction in the number of delayed discharges compared with where we were last year. I want to ensure that we do intense work this year on what more we can do to reduce delayed discharge, because we know that that is critical in supporting the flow into our hospitals.

We are doing a second element of work on reducing the level of demand at our A and E departments. For example, the work that the Scottish Ambulance Service is doing through its integrated clinical hub is reducing the number of people who have to be conveyed to our A and E departments, and that is as a result of the investment that we are making into that service.

We are doing work to improve those things, but demand is significant. I believe that we can still make further progress, and I am determined to ensure that we do that during the next year. We will continue to focus on the areas that we know will improve the performance that we get in our A and E departments and across our unscheduled healthcare system. We are making progress, but there is certainly much more to do, and there is determination to ensure that we do it.

**Sandesh Gulhane:** We now regularly have more than 1,000 drug-related deaths each year, and we seem to be going backwards in the care that we give to people with drug dependency. There has been a reduction, in real terms, in the budget. What is your commitment to that figure and to reducing the number of deaths, and how do you expect people to do that with less money?

**Michael Matheson:** We gave a commitment to increase investment to some £250 million during the parliamentary session to tackle the twin challenges of drug and alcohol misuse, and we are on track to deliver that and sustain that level of investment.

We are keen to see further growth in the provision of rehabilitation services, and work has been done to achieve that. The commitment that we made to ensure that there was sustained investment in drug and alcohol services is being taken forward in this budget so that we continue to see the progress that we need in the delivery of those services to improve outcomes for those who suffer from drug and alcohol misuse.

Funding for the drugs policy has increased by 67 per cent since 2014-15. There has been a sustained period of increased investment. We committed to ensuring that there was additional investment of £250 million to support our drugs and alcohol mission, and the budget builds on delivering that.

**Emma Harper (South Scotland) (SNP):** Good morning, cabinet secretary. I am interested in the NHS Scotland resource allocation committee formula and the review of that. I know that it is specifically calculated to support remote and rural places. Can you give us an update on the undertaking of a review of NRAC and a timescale for when we might expect to have the review in front of us?

**Michael Matheson:** We have allocated an extra £31 million in the budget to ensure that all boards are within 0.6 per cent of NRAC parity. The largest chunk of that goes to NHS Lothian and NHS Fife.

The review group is called the technical advisory group on resource allocation. It has met three times so far, and it is drawing together work to take forward the review of NRAC. I should say that it will not be a quick process. It will take a lot of detailed work to take forward any funding formula changes or developments. The group has already started commissioning the data and information that it requires in order to look at how it could adapt the existing NRAC formula. Richard McCallum might be able to say a bit more on how it is progressing.

09:30

**Richard McCallum (Scottish Government):** I can add a couple of things. The NRAC formula is still valuable in terms of the information that it provides to us. As the cabinet secretary has said, it is a really important mechanism by which we allocate funding, given that it takes into account a wide range of population and health factors.

As the cabinet secretary has just said, the group that is looking at it has met three times already. It will continue that work over the course of 2024 for the Scottish Government to review later this year; potentially, it will continue that work into 2025.

The commitment has been for the NRAC formula to be reviewed over the course of this parliamentary session, and, as officials, we are certainly committed to doing so. As I say, over the course of the next year, we hope to be in a position to introduce any potential changes.

However, even in its current form, the NRAC formula has value and a role to play. It is about ensuring that any refinements that we make are properly reviewed and scrutinised, which is what we will do.

**Emma Harper:** The committee is doing an inquiry on remote and rural healthcare right now, and I am sure that NRAC will help to inform us in our inquiry.

**Ivan McKee (Glasgow Provan) (SNP):** Talking a wee bit more about health boards, I would be interested to understand what processes are in place to do comparisons between health boards. Clearly, there are different challenges in different parts of the country, but there are also an awful lot of common challenges. What processes are in place to understand which health boards are better at performing and more efficient at delivering, and what mechanisms are in place for health boards to learn from each other, to learn from the best in class and to roll out best practice?

**Michael Matheson:** I will bring in Richard McCallum to talk about our work with boards on how we can share learning.

We have a formal process for monitoring all our boards' performance, not just in terms of key targets but around financial management. We also conduct an annual review process for each of our boards to evaluate the progress that they are making; they have an in-year review as well.

One challenge that has been around for a long time—I recall this from when I was previously a junior health minister—is trying to make sure that, where there is good practice in one part of the country, it is replicated in other parts of the country. That challenge is not peculiar to health; it is a challenge within the public sector overall. It is always a source of frustration to me that, in a country of 5 million people, we struggle at times to make sure that good practice is replicated and that where it is established, it sticks.

We have a number of different mechanisms through which we seek to do that. One is that we regularly bring our board chief executives together to focus on particular areas of challenge and, where they have taken new approaches, to share that practice. We do the exact same thing with the NHS chairs of the boards. I meet them every six weeks or so; we have the opportunity to focus on key areas where there is good practice or on areas where there are challenges, in order to try to encourage good practice.

We are also making much greater use of the centre for sustainable delivery, which is based at the Golden Jubilee National Hospital special NHS board. The centre was established to look at key areas where there are opportunities for efficiencies and improvement in service delivery. It takes that forward with individual boards and it can model what the impact would be on an individual board if it were to deliver something differently. It can also do specific work with individual boards.

Over the next couple of years, the centre will probably be the key mechanism that we will use to try to get greater consistency, to make sure that we are getting better adoption of good practice where it has been identified, and to bring new ideas to boards.

I will ask Richard McCallum to say more about what we do on finance with the boards.

We are taking forward a range of work to encourage the adoption of good practice where it has been established in one board.

**Richard McCallum:** Ivan McKee's challenge that there are different positions across NHS Scotland is right because, although all boards need to make savings and they all recognise some of the financial challenges that are being faced, not all of them are in the same position financially. For example, in 2022-23, 17 boards reached financial balance and five did not. As the cabinet secretary said, there is a formal mechanism through which boards that have not been in a position to do so can scrutinise the issues that they face and their areas of focus so that they can address their financial challenges.

More broadly, we work very closely with all the health boards, through the chief executives group and through directors of finance and other forums. A key measure that we have taken is the development of a list of almost 15 key areas, such as effective prescribing. That lets us look at the data on each area from across the country. I would be happy to share it with the committee. Sometimes variation among boards will be understandable and warranted and there will be a good reason for it, but often there will not be. The list has given us a mechanism through which we can expect boards to look at all 15 areas and assure themselves that they are doing all they can in each of them, but also through which we, from a Government perspective, can look at those situations and challenge boards and scrutinise where they might be off track.

Another of the areas is supplementary staffing. Going back to Ms Harper's point, in certain parts of the country it might be more necessary than in others, but it is important that we can see the variation across the country and carry out the appropriate challenge and scrutiny where necessary.

**Ivan McKee:** Is health board management well aware of where their boards sit in those 15 league tables, who is best and who they should be learning from?

**Richard McCallum:** Yes. That is very clear in the system.

**Ivan McKee:** Thanks.

**Carol Mochan (South Scotland) (Lab):** Good morning. My point probably links to things that my colleagues have said. It is about the sustainability of health boards and where we think that Government and the boards are required to work together. Cabinet secretary, you noted that there are five—although my papers said four—health boards that are indicating that they are having financial pressures.

What are the key actions that you are working on together in relation to financial sustainability? What three things are you working on together with the health boards that are on the escalation framework, particularly those that are at stage 3?

**Michael Matheson:** We have, I think, five health boards at stage 3 of the escalation process. It is important to emphasise that providing tailored support to boards that are experiencing specific financial pressures is not new. The mechanism has been in place and has been used at various points over the years. Clearly, though, we are in a very challenging financial environment, so we have boards that are under extra pressure.

I will get Richard McCallum to say a bit more on a couple of areas that he has just touched on. One area is how boards manage their staffing. There is the use of agency staff versus bank staff and the issue of recruiting staff. The second area is prescribing. There are marked variations among boards in prescribing and in the costs associated with it. Although we might procure a lot of the drugs in Scotland centrally, prescribing variations can have an impact. The chief pharmaceutical officer is doing work to ensure that we do as much as we can to get greater consistency in prescribing, because that can also address issues around the costs associated with prescribing.

Richard, do you want to say a bit more on some of the other work that we are taking forward to give support around financial sustainability?

**Richard McCallum:** Yes. I think that, broadly, there are three or four areas on which we are working most closely with boards.

I should just say that the five boards that I mentioned were from the outturn figures in 2022-23. Obviously, we are still working through the current financial year with health boards.

The major spend areas for health boards are workforce and medicines, so they are key areas on which we are doing work. I mentioned work on supplementary staffing and effective prescribing; that is key, as is ensuring that there is good practice in the areas in which there are opportunities to switch from patented drugs to generic ones, and other such opportunities. It is important that there is clarity about how that is done.

As well as that, we need to draw on work that can be done by the national special boards. NHS National Services Scotland does a lot of work on behalf of NHS Scotland. Good practice in procurement in prescribing is an area that it could support, but there are other areas as well.

We need to ensure that where there is a national approach to certain services, all boards are expected to play into that process—they are expected to work with each other to identify the best opportunities and best practice, as I said in my answer to Ivan McKee.

**Carol Mochan:** Okay. I have a couple more points relating to issues that are raised with the committee quite a lot. The first is about the way in which settlements are made and how multi-year is helpful. We hear that a lot from other sectors, and we have heard it in committee meetings. How are you placed to be able to offer that to some boards?

**Michael Matheson:** Do you mean multi-year budgets?

**Carol Mochan:** Sorry, yes.

**Michael Matheson:** Through our medium-term financial framework—I think that we published that in 2022. Is that correct?

**Richard McCallum:** Yes. It was the spending review.

**Michael Matheson:** Okay. Through the spending review 2022, we tried to set out an indication of budget for a three-year period. The problem is that we get only an annual budget, so we do not know what next year's budget will be. The challenge is the way in which the UK fiscal environment operates—it works annually. It is very difficult to give a commitment on what will happen during the next financial year when we do not even know what our budget will be for that year.

However, I agree with you that if we could get into a cycle in which we were able to provide a much clearer indication, during a three-year period, to allow organisations to plan more effectively, that would probably be a much more efficient way to manage services. It would give them certainty. However, the principal challenge that we have is that we have an annual budget, so we do not know what our budget will be the following year, which makes it almost impossible for us to make commitments into the following financial year. I agree with the premise that if we could do that, we should. However, fiscal change at UK level would be required to give us certainty during a three-year period.

**Carol Mochan:** Yes. You are right that it would be helpful for organisations to be able to predict whether they are likely to have similar funding or on-going increases in funding.

My last point is about NHS boards. Are the 3 per cent recurring savings considered to be achievable for NHS boards? What conversations have you had with the boards about whether that is realistically sustainable for them?

**Michael Matheson:** Boards have been expected to make recurring savings for some time now, so it is not new to them and they are well practised in it. It is key to ensure that there is a focus on efficiencies in boards. We discuss that with boards regularly, at executive and non-executive level, to ensure that they are looking at expenditure to achieve efficiencies where they can. That is no different during this financial year, and in some cases it is more important than ever, given the very tight financial environment in which we are operating.

Given the level of expenditure that boards have—more than £14 billion of taxpayers' money—it is important that we apply targets to them to ensure that they are driving efficiencies in the system where they can. That is not money that is lost to the system; it is money that is used in healthcare, but it allows us to ensure that we are getting as much efficiency out of the investment that we are making as possible. It is important that boards are given that challenge.

**Carol Mochan:** Finally, do boards indicate whether they have reached the point that that is becoming difficult for them? Do they say that they feel that they can continue to work at that 3 per cent level?

09:45

**Michael Matheson:** I think that most boards would say that they would prefer not to have to do it, if they could, but it is important that we set that challenge for them in relation to driving efficiencies in the system. It is a bit like the four-hour wait target at A and E; taking that away would probably cause more problems, because it drives some of the systems. The 3 per cent is a way of driving boards to make sure that they are looking at their expenditure and where they can be more efficient.

Notwithstanding the challenges that go with achieving that, it is an important challenge that we put to them. We make sure that we hold them to account for that, given the huge amounts of taxpayers' money that they are responsible for spending each year, and that they are doing that as efficiently and effectively as possible.

**Ivan McKee:** Can you unpick what that 3 per cent recurring savings point actually means? It is clear that the budget for health boards is increasing in cash terms and in real terms, but we are talking about 3 per cent recurring savings. I assume that that is on a like-for-like basis and the other money is going on additional stuff. Can you unpick that so that we know what that 3 per cent refers to?

**Richard McCallum:** To give you an idea of the scale of that, that is probably somewhere around £300 million to £400 million in cash terms. That recognises that there will be inflationary pressures for boards in some of the areas that we have mentioned. I will take drugs as an example. Inflation in drug costs in secondary care is rising at a significant rate, and it is important that boards have a focus on that, as well as on all the additional investment that is provided by the Government, and that there is an eye to that savings target.

In addition to the £500 million uplift that boards have received, there would normally be an expectation that they would make savings of 3 per cent. That is somewhere in the region of £300 million to £400 million.

**Ivan McKee:** I do not really understand that. You are giving health boards additional money in cash terms and in real terms every year, so when you talk about a 3 per cent saving, how does that manifest itself in the numbers? It is an increase, not a saving.

**Richard McCallum:** We do not take that 3 per cent off them.

**Ivan McKee:** How do you measure that? How do you know that they are making that saving if you are just giving them more money?

**Richard McCallum:** We get regular reports every month on board savings and savings plans. We allow for that money not to be returned to Government but to be retained within the system so that the board keeps any saving within its own system to invest in its priorities for that system, but we have oversight of where those savings are being made.

**Ivan McKee:** Okay. You need to be pretty hot on the process and the numbers to make sure that that is all on the straight and narrow—

**Richard McCallum:** Absolutely.

**Ivan McKee:** —because it is very easy to lose the numbers there.

**Richard McCallum:** As I have said, we get regular and detailed reporting on the clarity of reporting and the areas that boards are focused on, so that we understand that.

**Ivan McKee:** The implication is that boards are not only getting a 1.7 per cent increase in real terms but they are also getting a 3 per cent

increase through those recurring savings, which is in excess of health inflation, in effect.

**Richard McCallum:** That is correct. If you can achieve more with your savings, that is better for you, because you can invest more locally.

**Ivan McKee:** I want to unpick this. If you look at the budget and go down to level 4, which is the lowest that we go, you will see the health boards' individual lines. I am interested in understanding a wee bit below that, specifically the issues that are raised from time to time in relation to whether the health service is overmanaged and how much of the money gets spent on bureaucracy, administration, management and so on versus how much is spent on the clinical side and medicines. Do you have clear visibility on that by health board? Are those numbers available for analysis?

**Richard McCallum:** We do not publish that at the time of the budget, but the NHS cost book is published on an annual basis for the previous year. That sets out in detail what is spent across a range of category lines. The next update from Public Health Scotland, which publishes that data, will be in February. That will set out in detail the total spend that we have set out in the budget and where that money is going by individual line.

**Ivan McKee:** Okay. So you have visibility on that. I would be interested in seeing that.

**Richard McCallum:** Yes.

**Ivan McKee:** To what extent are health boards co-operating with one another to identify shared services and functions that they can combine, such as back-office functions, to reduce costs?

**Michael Matheson:** It is probably fair to say that such co-operation is variable. Some boards jointly commission services on a planned basis where they think that it is in their mutual interest to do so. That is on a voluntary basis—the boards can choose to co-operate in that way if they wish to do so—and there is a mechanism in place that they need to go through if they want to provide backroom functions such as human resources functions on a shared commissioning basis. I am making that approach mandatory. A range of boards probably could do more in relation to sharing some of their backroom functions, and we have already indicated to the boards that they are required to take that approach.

**Ivan McKee:** Good.

**Michael Matheson:** As I said, that will cover HR functions, including payroll, that can be managed jointly.

**Ivan McKee:** Okay. Thanks very much.

**David Torrance (Kirkcaldy) (SNP):** Good morning to the panel members. How can the twin pressures of increased pay and demands for additional staff be balanced in the NHS and in social care within the constraints of the budgets?

**Michael Matheson:** The staff are key to the health service, and it is important that we provide them with the financial recognition for the important role that they play. That is why, in the past financial year, we have progressed our agenda for change commitments; it also accounts for how we have engaged with staff on pay negotiations. The pay increase inevitably creates financial stress in, and challenge for, the system, but it is critical that we do that, because staff are key to the delivery of our health services. The increase will have to be met within the existing budget allocations that are set out in the 2024-25 budget.

On social care, a key aim of our additional investment of over £800 million in the past couple of years is helping to address the pay issues in social care settings. We know that pay is a major challenge when it comes to recruiting into social care, and we also know that social care is critical to the performance of our NHS. Therefore, if we want our health and social care system to function effectively, we must ensure that we provide resources where we can to pay staff for their important role. That is the approach that we have taken on negotiations and through the agenda for change programme in relation to pay for health and social care staff.

**David Torrance:** On higher NHS pay, what effect will that have on service delivery if non-staff budgets need to be reduced to fund the increased pay offer?

**Michael Matheson:** I am sorry—I missed the first part of your question.

**David Torrance:** What effect might the increase in NHS pay have on service delivery if non-staff budgets need to be reduced to fund the increased pay offer?

**Michael Matheson:** Okay. We can look at that in a number of ways. Yes, increasing staff pay places a challenge on the budget, but I do not grudge them that at all, given their important role. That means that it will not be possible to make some of the investments that we might want to.

However, the impact of not increasing pay for staff and not settling such types of issues is also very costly in financial and service delivery terms. If we were not able to reach a settlement on some of the pay deals, we would inevitably face industrial action, which we know has significant financial cost to the NHS.

Let us take the industrial action by junior doctors in England as an example. I think that that has cost more than a billion pounds as a result of all

the additional measures that must be put in place to try to cover absences during such action. In addition to that, around 1.2 million appointments have been cancelled, which has an impact on overall service delivery.

We have to recognise that, if we do not invest in our staff and do not try to resolve those types of issues in a co-operative fashion, that can be hugely disruptive and very costly for the way in which the NHS is able to deliver its services. The approach that we have taken is to try to help to resolve those matters in a fair and reasonable way with the employee side, but that, of course, has a financial impact on wider service delivery. You may not be able to expand services in the way in which you would wish to, given the financial environment in which we are operating. Notwithstanding that, the way to invest in services is by investing in staff. I view pay uplifts for staff as an investment in our NHS.

**Ruth Maguire (Cunninghame South) (SNP):** I will stick with the social care budget. Forgive me—you mentioned some of this in your opening remarks, but I think that it is worth getting clarity for the record. What is the total level of planned spending on social care for 2024-25? How does that position compare with what the Scottish Government inherited in 2006-07? How does that increase compare with the received Barnett consequentials?

**Michael Matheson:** The total budget for social care in 2024-25 is just over £1 billion and, in 2022-23, it was £879.6 million. That is a £200 million-plus increase, which is a reflection of the additional investment that we are putting in to increase pay in social care.

I do not think that I have a figure on what we inherited. I would have to come back to you with that, because that goes back to the 2006-07 budget.

**Ruth Maguire:** Are you able to tell the committee how that increase compares with the Barnett consequentials that the Scottish Government has received?

**Michael Matheson:** By and large, we do not get a Barnett consequential for social care. There is no direct Barnett consequential for that in the way in which there is for health.

**Ruth Maguire:** Okay. It can be challenging to get clarity on the social care budget because of the way that the money flows between the Government, health services and local government. The Scottish Government committed to increasing spending on social care by 25 per cent over this parliamentary session. Can you remind the committee of the progress that has been made on that?

**Michael Matheson:** We have already met that target—we are ahead of schedule on it by two years, I think. That has already been delivered within this parliamentary session.

**Ruth Maguire:** You have touched on the importance of social care for the whole system. We talk about health and social care separately, but the services are intrinsically linked, particularly from the perspective of patients. Good-quality services in the community often prevent hospital admissions, particularly those that are unscheduled. How does the Scottish Government make decisions about the appropriate balance between money going to social care and money going to other areas of health?

**Michael Matheson:** There are a couple of different routes through which money flows into social care. We provide funding to local authorities. Some health boards will invest in social care provision alongside some of the central funding that we provide for social care. That is largely for things such as pay uplifts. The scale of financial demand in health is markedly different from that of social care. Obviously, healthcare gets the lion's share of the funding. We have made a deliberate decision to ensure that we increase investment in social care, particularly in staff, in order to increase or sustain the capacity of the service, because we know that it is under significant pressure.

10:00

One of the things that it will be absolutely essential to deliver as part of our reform programme is a national care service through which we can ensure that there is a greater consistency of approach to the provision of social care and that that aligns with the NHS much more effectively. We can see variation across the country, and that impacts on how social care services are received by individuals who require social care support and on the performance of the NHS.

Going forward, we will need to see even further investment in social care, and we will also need to see service reform. A national care service is going to be critical to ensuring a much more consistent approach to how social care is delivered and provided in the country, and one that aligns much more effectively with the NHS and helps to support it. Further investment and service reform are going to be critical.

**Ruth Maguire:** We are thinking about the budget. Will that service reform make it easier to move budgets and move resource into the community?

**Michael Matheson:** I do not know whether it will make that easier, but it will give us the ability to be

much clearer about the outcomes that we are looking to achieve with that investment and the public expenditure that goes into social care, and it will give us the ability to seek to achieve much more consistency.

It has benefits for staff, such as allowing for collective bargaining, which I know is an important issue for trade unions. The creation of a national care service will be critical to supporting us to achieve a more attractive place for folk to work, greater consistency in how services are delivered, and better alignment with the needs of our NHS. It will also help us to get greater consistency in how funding is used and ensure that it is being used to achieve better outcomes for individuals who need to make use of those services, in a way that we do not have at the present moment.

**The Convener:** I am aware that many members have not had an opportunity to ask questions yet. I will bring in Sandesh Gulhane to ask a brief supplementary question, and then Tess White.

**Sandesh Gulhane:** Cabinet secretary, we were speaking about the national care service and you said that there is £1 billion in the social care budget. How much of that budget line relates to the NCS and how much relates to adult social care funding?

**Michael Matheson:** About £15 million is for the national care service.

**Tess White (North East Scotland) (Con):** I have a question about reinforced autoclaved aerated concrete. It is not clear exactly how many properties are affected by RAAC or what the remedial action will be. Can you give us an idea of the cost, based on surveys that have taken place to date, and how long the remedial action will take? Over what period will it be carried out?

**Michael Matheson:** Are you not aware of the work that Health Facilities Scotland has been taking forward? I think that 254 properties were initially identified in the desktop exercise. They all had an initial risk assessment, and work—including intrusive survey work—was carried out before the end of the year. An update on each of those projects was published online.

**Tess White:** Are you aware of the cost and the timescales for remedial action?

**Michael Matheson:** Two hundred and fifty-four properties were identified as priorities. I think that only one property had to be vacated—actually, it was in the process of being vacated anyway. The vast majority of the others require only additional monitoring. That information is all publicly available. Health facilities Scotland has that on the NSS website, and each individual health board has published information on that as well.

Once health facilities Scotland had completed that work—as I stated previously, it was completed on time before the end of last year; I think that it was completed before the end of November—some additional sites were identified that were not previously known about. Some of those are not facilities that are directly owned by the NHS; they might be GP surgeries and so on. A programme of survey work on 100 or so such buildings is being taken forward. That information is all publicly available.

**Tess White:** Are you able to give a figure for the costs and a timescale for remedial action?

**Michael Matheson:** The work that was carried out last year did not identify—

**Tess White:** So there were no costs.

**Michael Matheson:** —any remedial work that was required, other than the normal routine maintenance work that boards do. Instead of surveys being carried out every three years, they are being carried out every year, and there are details on the types of things that should be taken forward. However, no major costs were identified from the survey work that was carried out by health facilities Scotland.

**Tess White:** Just to confirm, there were no significant costs and there was no significant remedial action.

**Michael Matheson:** There were no significant works and there was no major disruption to services. In the few areas where work was needed, it was done as part of normal routine maintenance work.

**Tess White:** Good. Thank you. My second question relates to the capital investment budget. In recent years, the work on designing and delivering hospital infrastructure projects has unfortunately been beset with delays, overspends and, sadly, an unthinkable tragedy at the Queen Elizabeth university hospital in Glasgow.

NHS Grampian has conceded that there are serious issues, as we have discussed previously, with the design of water and ventilation systems for the Baird family hospital and the Aberdeen and north centre for haematology, oncology and radiotherapy—ANCHOR—centre. Those issues have created significant pressure on the project budgets, but the health board has said that it is very difficult for it to quantify the financial impact of such issues. Can you confirm what headroom, if any, is available in the latest capital investment budget for the Baird family hospital and ANCHOR centre projects in order that they can be completed? Have such issues been factored into the budget?

**Michael Matheson:** The capital budget for the Baird hospital and ANCHOR centre projects is

what was originally agreed. Within the overall project—

**Tess White:** So there is no extra money.

**Michael Matheson:** There is no additional capital budget. Our capital budget has been cut by the UK Government by 10 per cent, and the construction costs for projects that are already in delivery have increased. We are trying to use the capital budget as fairly and reasonably as we can, but no additional money is available because of the cut that we have experienced alongside the construction inflation that projects face.

**Tess White:** As you can imagine, that is extremely worrying. If no extra money is being provided for a hospital that has major design flaws, there will be serious questions about delays to completion.

**Michael Matheson:** NHS Grampian is taking the project forward. Through NHS Scotland assure, we will provide the health board with as much support and assistance as we can to ensure that it gets these things right and addresses any changes that have to be made. However, I am afraid that there is no additional headroom in the capital budget, given the cut to that budget by the UK Government. That has a direct impact not only on capital projects relating to health, but on capital projects right across the Scottish Government, so any additional costs will have to be met within the overall project budgets.

**Tess White:** You are in control of the budget, but you are blaming the UK Government.

**Michael Matheson:** Our capital budget is dependent on the capital allocation that we get from the UK Government, which has cut our capital budget by 10 per cent. As a consequence, there is less capital funding available to invest in capital projects in Scotland. On top of that, we are experiencing significant challenges as a result of construction inflation. Indeed, some projects have almost doubled in cost as a result of the construction inflation that has been experienced over the past year to 18 months.

Not only are there increased costs for projects but, as a result of the UK Government's decision to cut our capital budget, there is less money to invest in capital projects. That is a direct consequence of the decision by the UK Government to cut our capital budget.

**Gillian Mackay (Central Scotland) (Green):** Good morning, cabinet secretary. Preventative spend is often difficult to track and quantify, particularly once it goes into health board budgets, and the health benefits often take a long time to show up in population health data. How does the Scottish Government track and evaluate preventative spend? Do you believe that the data needs to be improved if we are to further target preventative spend?

**Michael Matheson:** There are a number of different ways in which we try to invest through preventative spend. It is normally around behavioural change programmes on things such as alcohol and drug use, eating habits and smoking. All of that work is about prevention and trying to reduce the health consequences that we experience as a result of those challenges. Much of that work is done through marketing campaigns and service delivery programmes, for which we fund the NHS boards. Many programmes will have targets. For example, smoking cessation programmes have a target for the number of people that they help to stop smoking. We are therefore able to monitor the progress that boards make against such targets.

We invest in a number of areas. For example, we are taking forward some innovations around type 2 diabetes remission, type 2 diabetes prevention programmes, the digital dermatology programme, vaccination programmes and artificial intelligence for lung cancer. We use all those programmes to help to do more in the preventative space through the use of innovation.

How have we identified some of the things that we have taken forward? We have a programme called the accelerated national innovation adoption pathway, which is run in partnership with the chief scientist office to identify areas for investment in preventative spend and things that we know will have a significant impact in improving outcomes. We use a once for Scotland approach to identify the most appropriate areas for investment in new technologies in NHS Scotland to support preventative spend.

We can evaluate those programmes as they are rolled out and as those investments are made. With the combination of programmes that we run and evaluate through health boards for preventative healthcare issues and the ANIA programme, we target innovations that we know can help to prevent ill health and improve outcomes for individuals, and we assess the most effective routes for making the investments and evaluating their impact.

**Gillian Mackay:** It is sometimes difficult to achieve a shift to preventative spend when there is acute need in the system. I am pleased that a consultation on a public health supplement, which my party has long backed, has been proposed through the budget. Do you believe that such a measure could help to drive preventative spend?

**Michael Matheson:** Yes, I think so. There is always an ambition to invest much more in preventative healthcare where we can. That is challenging when we are in a very difficult financial

environment and given the significant demand that services are facing. Notwithstanding that, however, we should do that where we have the opportunity. We have committed to exploring issues around a public health levy over the next year and I think that, if its introduction is agreed to, it would provide an opportunity for investment in other areas of preventative spend.

We should also recognise that innovation in technology can play an important part in some of the preventative approaches that we pursue. I mentioned the work on diabetes. New digital technology could have a real impact in reducing the side effects that people can experience as a result of diabetes and in helping them to live more healthily. We know that that will have a preventative effect in the future because of the benefits that come from it. We know that the use of AI in radiography can help to identify issues at an earlier stage and allow for earlier intervention, which could further reduce expenditure in the future.

Technology and innovation can play a really important part in ensuring that we do more in the preventative space, and any additional investment that might come through a public health levy in future years to support that would be very welcome.

10:15

**Gillian Mackay:** The cabinet secretary and I have had many conversations about vaping and its impact on health. Given how quickly novel products can affect health, what impact are they having on preventative spend budgets? Is the way in which we allocate those budgets flexible enough to adapt if those products are having an in-year impact on health?

**Michael Matheson:** I am not sure whether we have enough flexibility. That brings me back to the point that Carol Mochan made about the challenge that we face in giving organisations budgets to take programmes forward over the year that then have to be adapted and changed in year when we get information about something coming on to the market. I will have to think about what more we can do to allow some flexibility in that respect.

With regard to vaping, the sector has grown to quite a marked degree—indeed, it has grown exponentially—over the past number of years. It is associated not only with health issues but with environmental consequences, and there is a need for stricter regulation around it. In fact, we are taking forward the joint consultation with the other nations to look at what further restrictions should be put in place. There is no doubt in my mind about the need for proactive action on the part of Government in the preventative space.

I will take away your point about in-year flexibility, but I am conscious of some of the challenges that we face with regard to the way in which we fund organisations if we are looking for them to adapt in the course of a financial year.

**Gillian Mackay:** That is okay. Thank you.

**The Convener:** Emma Harper is next.

**Emma Harper:** I want to pick up on Gillian Mackay's question about preventative spend and the point about the diabetes-related work. In the previous session of Parliament, I was interested to find out that investing more in prevention would mitigate a lot of NHS spend. For example, the NHS spends £772 million on obesity-related conditions. What would happen if we could, up front, prevent or reverse type 2 diabetes or help to manage people's weight?

I note that the Public Health Scotland budget was £56.3 million in the current year and that it is proposed to be £57.5 million next year, which represents an increase. Public Health Scotland is taking a whole-systems approach to diet and healthy weight, but it is not just the health budget that is impacted by these things. The social care budget also seeks to tackle poverty, which is part of what leads to, for example, poor diet. Is work being taken forward or happening that is not specific to one portfolio but brings in other portfolios to help to inform the action that is taken? What I am suggesting is that it should not just be up to the health budget to manage some of the challenges that we have in tackling poverty and managing weight; other portfolios should support that work, too.

**Michael Matheson:** The fact is that it is very often the NHS that has to deal with the consequences of lifestyles that result in ill health, but other services could do more to prevent such issues from arising. As the evidence shows, the investment that we are making in areas such as the early years is critical in helping to improve outcomes for children and young people. We have seen internationally that early years intervention is much more effective in helping to improve outcomes not just for children but later in life, too.

Our investment in approaches to tackling child poverty, such as the Scottish child payment, will help to reduce some of the risks that are associated with child poverty, which can have an impact on an individual's health and their long-term wellbeing. There is also the best start programme. Those measures, some of which are health related and some of which sit in other portfolio areas, can have an impact in helping to improve health outcomes.

If we look at the disease tree of obesity and all the different branches that come off it, from cardiovascular and respiratory issues to diabetes

and all its consequent issues, including neuropathy and so on, we can see that, if we tackle some of the root areas more effectively, we will head off some of the other health complications that are consequent to the condition. As I suspect you recognise, tackling obesity is critical to helping to reduce demand on cardiovascular, diabetes and some respiratory services and everything that goes with that, and doing so would have a preventative benefit in the future.

That said, the biggest risk that we have in tackling these challenges, particularly the health inequalities that we are experiencing, is that two key areas are moving in the wrong direction. Mortality rates are increasing and health inequalities are widening—as they have been for more than a decade now, largely as a result of austerity. All the evidence demonstrates that, as the social protection system is reduced, the impact that that has in increasing mortality rates and inequalities gets greater. We have been going through that in the past 10 years, which is why that data is going in the wrong direction.

There are certain things that we can do to try to mitigate some of that, but it is clear to me that the austerity that we have had for more than 10 years and the austerity that we are experiencing at an even greater level just now will result in people dying prematurely because of the impact that it has on the social protections that people depend on. It is probably one of the biggest public health challenges that we face going forward. If there is one thing that I would do to tackle health inequalities and their consequent problems, it is to tackle the economic policy around austerity. That would have the biggest impact in helping to reduce some of the very marked inequalities that have been expanding in recent years.

**Emma Harper:** I forgot to remind everybody that I am a registered nurse with the Nursing and Midwifery Council. I should have said that at the beginning.

**Paul Sweeney (Glasgow) (Lab):** I want to come back to the detail of mental health expenditure. The Government's long-standing target is to achieve a 10 per cent allocation of front-line NHS expenditure to mental health services by the end of the current parliamentary session. The current allocation sits at around 8.8 per cent, which represents an actual expenditure shortfall of £1.8 million. How does the cabinet secretary intend to achieve the target by the end of the parliamentary session under the current curve?

**Michael Matheson:** You are right that mental health services are about 8.8 per cent of our expenditure at present and I hope that we will have those services at 10 per cent by the end of this parliamentary session. That will depend on future budgets and the availability of finance, but it would certainly be our intention to do that. As I said earlier, however, there has been a very significant uplift in mental health expenditure since 2020-21. The level of Scottish Government investment in the area has more than doubled, but 10 per cent is still our ambition. We are at 8.8 per cent and we need to look at whether budgets in future years will allow us to continue the increase to achieve a 10 per cent allocation.

**Paul Sweeney:** Cabinet secretary, you highlighted the longer-term increase in mental health expenditure. The 10 per cent target was set by the Government and progress towards it has stalled. It is certainly stalling this year and we are going backwards in real terms. Is there a high risk of not achieving the target? Is there a red flag against the target to say that we will be challenged to achieve it by the end of the parliamentary session?

**Michael Matheson:** It is a reflection of the difficult public financial environment in which we are operating. Although we are not able to make all the increases that we would like, we have made a significant increase in the past couple of years. Sustaining that in the present financial environment is really challenging. We have sought to protect mental health funding as best we can and to sustain the significant increase in investment that we have made in the past couple of years, but whether we will be able to increase that further will depend on budgets in future years. If the present approach to public finances continues, it will be really challenging to do that, given the pressures on public sector budgets right across government.

**Paul Sweeney:** An area of particular concern that was mentioned earlier is the real-terms cut to drug and alcohol service budgets. I think that they are down 1.6 per cent this coming financial year, which represents a real cut of £100,000 or so. It might seem quite minor, but it is having a direct effect, such as the proposed closure next month of Turning Point Scotland's 218 service in Glasgow, due to the funding settlement from the integration joint board in Glasgow of just £650,000, down from £1.3 million. That was described by Turning Point Scotland as unworkable, thus it is closing down the service, which will potentially impact women's mental health and the recovery of people who are suffering from addiction and possibly also interacting with the justice system. I am also cognisant of preventative spending and the need to rehabilitate people.

Will the cabinet secretary consider engaging directly with Glasgow City Council and the health and social care partnership to find a way to possibly salvage the service, the loss of which

could have a big impact on the healthcare budget? I know that the service interacts with justice, but it has a cross-cutting effect on healthcare as well.

**Michael Matheson:** I think that the 218 service came through the justice funding that went into IJBs; it was not from health funding. I am not entirely sighted on exactly what has happened with the justice funding. I think that it would probably go back to the old justice boards and the funding that was transferred across to IJBs, rather than coming directly from the health portfolio. I would imagine that it is a matter that the justice secretary would be able to respond on, because it is not something that sits directly in my portfolio.

**Paul Sweeney:** That is a fair point, but would you, as a stakeholder, given the clear impacts on the healthcare system, make representations to your colleague to find a way through this?

**Michael Matheson:** I am more than happy to ask the justice secretary to respond to the issues that you have raised, given that it is a justice-led area rather than a health-specific area.

We made a commitment to invest an extra £250 million in the twin areas of drug and alcohol services over the course of this parliamentary session and we are on track to achieve that. That is an increase in investment over the past couple of years and we want to ensure that we continue to make progress with that.

It is down to local partners to determine how they think that funding should best be delivered at a local level. Some of the services that might operate around alcohol and drugs issues are not funded directly by the health portfolio—they sit in other portfolio areas. I am more than happy to ask the justice secretary to respond to the concern that you have raised about the 218 service.

**Paul Sweeney:** That is very kind. I have a quick question on the issue that has been raised by NHS staff in Glasgow about safe staffing levels. Do you monitor where there are potentially dangerous levels of understaffing and target resource expenditure to ensure that there is a minimum safe staffing level across the healthcare system, particularly in acute hospitals?

**Michael Matheson:** We do not micromanage services on the ground within individual health boards, but, clearly, there is a requirement for boards to ensure that there are safe staffing levels. Where there are concerns, there is a mechanism for staff to raise them and escalate them within the board.

There is a lot of work going on around the safe staffing legislation that we introduced. If concerns have been raised with you directly by staff, they should escalate them through the local mechanism to ensure that they are addressed. My expectation is that boards would address such concerns and do so quickly.

**Paul Sweeney:** To confirm, that is not something that would necessarily be escalated to your directorate or your department directly—if potentially dangerous staffing levels were flagged up, that matter would be contained at board level. I am just curious as to how the matter would be escalated up the chain.

**Michael Matheson:** It is an operational issue, so I would expect it to be dealt with by boards. They have a whole executive team, so if there was an issue around safe staffing in a particular ward, I would expect that to be escalated through the board's local management structure—eventually, I presume, to the director of nursing and, if necessary, to the chief executive.

If a wider systemic problem was being experienced and it was brought to our attention, we would certainly want to raise that with the board. In terms of day-to-day operations, it would be the responsibility of the individual board to deal with the matter. However, if there was a wider systemic issue, I would certainly be concerned about that and I would want to take action if there was a problem in a board.

**Paul Sweeney:** That is great; much appreciated.

**The Convener:** I thank the cabinet secretary and Richard McCallum for joining us this morning. I will briefly suspend the meeting to allow for a change of witnesses for the next agenda item.

10:29

*Meeting suspended.*

10:37

*On resuming—*

# Subordinate Legislation

## Anaesthesia Associates and Physician Associates Order 2024 [Draft]

**The Convener:** Our third item of business is consideration of an affirmative statutory instrument. The purpose of the instrument is to allow the statutory regulation of anaesthesia associates and physician associates by the General Medical Council. The instrument provides a framework for AA and PA regulation and establishes the powers and duties in relation to the GMC, including the autonomy to set out the detail of its regulatory procedures in its rules. The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 9 January 2024 and made no recommendations in relation to it.

We will have an evidence session on the instrument with the Cabinet Secretary for NHS Recovery, Health and Social Care and supporting Scottish Government officials. Once all our questions have been answered, we will proceed to a formal debate on the motion. I welcome Michael Matheson, the cabinet secretary; Rachel Coutts, from the Scottish Government's legal directorate, specialising in food, health and social care; Nigel Robinson, the unit head for professional health regulation in the chief nursing officer directorate; and Scott Wood, the unit head for sponsorship and infrastructure in the health workforce directorate.

I invite the cabinet secretary to make a brief opening statement.

**Michael Matheson:** This statutory instrument is first and foremost about patient safety. Safe, effective and person-centred practice is the driving force behind how we deliver healthcare in Scotland and patients have a right to know that they are being cared for by professionals with the appropriate level of assurance and accountability.

People in the roles concerned have been practising across the UK for 20 years now and we cannot delay regulation any longer. With numbers and skills continuing to grow, we must introduce consistent UK-wide standards that are supported by meaningful sanctions when they are not met.

The instrument is also a significant stride along the road to meaningful reform of the regulation of health professionals, which I know several members around the table today will appreciate.

In bringing these devolved professions into statutory regulation, the order also brings the General Medical Council within the competence of the Parliament, and therefore this committee, for the first time. The regulatory landscape is complex and unwieldy, with each regulator operating within its own legislative framework. There is too much inconsistency and bureaucracy, which restricts the ability to swiftly adapt to the evolving demands on our health services without recourse to legislation.

The order is the culmination of years of collaborative working between the four Governments of the United Kingdom and multiple public consultations. As such, it is the first step towards a more modern and flexible model of regulation, establishing the first generation of a framework that will ultimately apply consistently across the health professions.

The order requires the GMC to set up a register and to put in place processes around education and training, fitness to practise, offences and appeals for the roles concerned. I must acknowledge the pejorative commentary around those roles in recent weeks, across both social and mainstream media. That relentless negativity has been detrimental to our physician associates and anaesthesia associates and I hope that this statutory regulation will promote respect for their contribution to our healthcare system. It is important to note that, although each of the Governments agrees that regulation is necessary, decisions on the utilisation of the roles in NHS Scotland will be taken by the Scottish ministers, based on what is best for the people of Scotland.

Our wider approach to the development of the workforce will be informed by our newly established medical associate professions—MAPs—implementation programme and overseen by a programme board that is made up of a range of key partners. We expect the board to meet for the first time next month.

I am of course happy to respond to any questions that the committee may have.

**The Convener:** Thank you for that opening statement.

Before I begin, I refer members to my entry in the register of members' interests, which shows that I hold a bank staff nurse contract with NHS Greater Glasgow and Clyde and that I am a mental health nurse registered with the Nursing and Midwifery Council.

Am I correct in thinking that the order follows on from a 2019 agreement with the UK Department of Health and Social Care, along with discussions with all the other devolved health departments, about the GMC taking on the regulation of AAs and PAs?

**Michael Matheson:** Yes, it is part of a long-standing piece of work that we have been taking

forward with the UK Government. Back in 2019, the then Cabinet Secretary for Health and Sport signalled agreement with the UK Government that we should introduce legislation to regulate AAs and PAs. However, there were issues around the wider regulatory framework, which was part of that discussion, and with carrying out a significant review of the regulation of healthcare professionals. The view was that trying to do all that at one time would not be effective, because it was too complex, and it was decided to deal with the AA and PA aspect of regulation separately from the wider work on health regulation. That is a separate piece of work, which is why the AA and PA aspect is being dealt with through a standalone order.

**The Convener:** Thank you for that clarification.

I welcome your statement on some of the commentary that there has been on healthcare professionals working as AAs and PAs. How do you respond to the claims that having the GMC as a regulator will add to confusion between doctors and AAs and PAs. How can that be mitigated?

**Michael Matheson:** I have heard some of the commentary on that, and I do not subscribe to it. We have a range of health regulators that regulate a range of professional groups. In my view, the GMC taking on the regulation of AAs and PAs will not cause any confusion, so long as there is a clear regulatory body that is responsible for dealing with any issues relating to AAs and PAs. I have heard some of the commentary, but I am not persuaded by it, given the fact that we have a range of other regulators that cover a variety of professional groups. I do not see why that would create any confusion for the GMC, given that it does not do so for other health regulators.

10:45

**The Convener:** Has the cabinet secretary considered making the Health and Care Professions Council—HCPC—a regulator for PAs and AAs? If consideration was given to that, why did you decide, as have other parts of the UK, that regulation by the GMC would be more appropriate?

**Michael Matheson:** There was a consultation exercise, part of which was about which regulatory body would be most appropriate for the regulation of PAs and AAs. A significant majority of respondents—just under 60 per cent, if I recall correctly—to the consultation said that the GMC would be the most appropriate body to carry out that regulatory function. The order, and the approach that both the Scottish and UK Governments have taken, reflects the feedback from that consultation exercise.

**The Convener:** Thank you, cabinet secretary. That was very helpful.

**Sandesh Gulhane:** I declare an interest, as my entry in the register of members' interests shows, I am a practising NHS GP.

I agree with the expansion of the multidisciplinary team, because we need to ensure that we have appropriate staff. However, I have a number of concerns about physician associates and anaesthetic associates. The first is about confusion. Why did the name change from "physician assistants" in 2003 to "physician associates" in 2014, and why are we sticking with "physician associates"?

**Michael Matheson:** I will ask Nigel Robinson to talk about the history going back to 2003, and why there was a change in the name at that point.

**Nigel Robinson (Scottish Government):** It is important to note that the role of physician associate arrived from America around 20 years ago. Physician associates have been established here for quite some time, notably in NHS Grampian in partnership with courses run by the University of Aberdeen. Those courses have been running for that duration, so we already have a cohort of practitioners in place who have attained accredited qualifications using that title, and courses that use it are currently running. There would be significant problems with changing the title retrospectively. We believe that doing so would result in unacceptable delays to the further legislation that is needed to bring PAs into statutory regulation, which is absolutely necessary for patient safety.

**Sandesh Gulhane:** They are not regulated currently, so if you are creating legislation, you can put in any name you want.

**Nigel Robinson:** We could, but not with this legislation: it would have to fall in both this Parliament and in the UK Parliament and the whole process would have to start again. As it looks as though this will be a UK election year, we would have no guarantee as to when we would be able to bring the roles into statutory regulation.

**Sandesh Gulhane:** The BMA is telling us that patients and their families are unaware, many times, whether or not they have been assessed by a doctor. Following on from the convener's last question, would it not add to that confusion to have the GMC regulate somebody else, seeing as it regulates doctors?

**Michael Matheson:** I have heard that argument a few times, but I do not quite follow it. There are other professional regulatory bodies that cover supplementary groups; for example, in pharmacy, the regulator covers groups other than just pharmacists. I do not follow the argument that, in

some way, the GMC taking on the role of regulating PAs and AAs will cause public confusion around the role of the GMC. If you have a complaint to make about a PA, an AA or a doctor, and their responsible regulator is the GMC, you take the complaint to the GMC. I do not follow the argument that, for some peculiar reason, it will become confusing if the GMC regulates two other groups besides doctors, given that other regulatory bodies do that and it does not appear to cause any difficulty for the public when pursuing a complaint or an issue with the relevant regulatory body.

**Sandesh Gulhane:** Can we talk about money? The cost of regulating a PA will be half the cost of regulating a doctor, and the Government is putting in money to subsidise the regulation process. Is that fair?

**Michael Matheson:** Eventually, it will be a self-funding model, but the proposed arrangement will operate for the initial couple of years, in order to get the regulatory process up and running. As the workforce expands, it will be a self-funding model, which is the way in which most of the regulators now operate. The proposed arrangement is part of the initial process to support the GMC in taking on the regulatory role.

**Sandesh Gulhane:** What about my point about the cost of regulating a PA being half that of regulating a doctor?

**Michael Matheson:** I do not know what the exact costs associated with that are, but the UK Government has decided to fund the GMC to support the introduction of the regulation of PAs and AAs. Eventually, we will move to the normal self-funding model, which the majority of the regulators, if not all of them, operate.

**Sandesh Gulhane:** In order to regulate, it is necessary to have very tight definitions of what it is that the profession is doing. There are very tight definitions around nursing and expanded roles and around what doctors do. Given the scope of practice of AAs and PAs, 69 per cent of respondents to a BMA survey said that they were concerned that their role had been expanded more than it should have been. An example that I have heard of is the medical registrar bleep being held by a PA. The holding of that role is one of the most senior positions in a hospital. What is the scope of practice for a PA when it comes to the complaints procedure and the regulation process?

**Michael Matheson:** At present, PAs are unregulated. In Scotland, we have a very small cohort of around 150 of them operating in the NHS. Back in 2016, we issued direction around the type of role and the scope of role that could be held by a PA in NHS Scotland, so that is already defined. As the GMC takes on the regulatory function, it will be responsible for setting out the relevant definitions and the terms of those definitions.

**Sandesh Gulhane:** The GMC has said that that is not its role. In the work that you have put out, you have not defined what supervision means.

**Michael Matheson:** How we use PAs and AAs in NHS Scotland will be determined by us. That will be the approach that we will take through the group that we have set up. As I mentioned, it will consider the role of PAs and AAs.

We have taken a very different approach from that of the UK Government, about whose approach to the matter the BMA has flagged up concerns. The use of PAs and AAs is a key part of the UK Government's workforce plan, and a lot of concerns have been raised about the proposed fairly rapid expansion of their use. I understand that, which is why we have taken a different approach here in Scotland. I have outlined to the BMA that we will take much more of an incremental and evidence-based approach to how PAs and AAs will be used in NHS Scotland and how they will be deployed and utilised in the workforce. We have put in place a process to manage that.

We do not intend to replicate the rapid expansion of the use of PAs and AAs that the UK Government is planning in NHS England. We are taking a much more evidence-based approach to their use and how that will be defined, which will be much more limited.

**Sandesh Gulhane:** Are you doing work on that? Are you planning to set up a programme?

**Michael Matheson:** I mentioned that in my opening comments. We have set up the medical associate professions implementation programme, which has a board that includes key partners from NHS Scotland and the royal colleges. The purpose of that programme is to ensure that, going forward, we have a clear implementation process for PAs and AAs as regulated professionals and how they will be deployed and used in NHS Scotland.

I have also set out clearly to the BMA the difference between the approach that we are taking and that of the UK Government. Many of the BMA's concerns relate to the way in which the UK Government has dealt with the regulation of PAs and AAs and how it has set that out in its workforce plan, which has conflated two issues. We are taking a different approach in Scotland: it will be much more evidence based and managed and those roles and the way in which they will be used in NHS Scotland will be clearly defined.

**Carol Mochan:** I totally agree that regulation is really important. I should declare that I was on the Health and Care Professions Council, although

that was about 15 years ago. It regulates a very diverse group of professionals and it is quite used to playing that sort of advanced role. Was there a debate about whether those roles sat neatly on the GMC or the HCPC, given that the HCPC is very skilled in those diverse roles with advanced practices?

**Michael Matheson:** I go back to my earlier answer. There was a debate around that, and it was part of the consultation in which we asked for feedback on which body would be the most appropriate to regulate PAs and AAs. The very clear majority—just under 60 per cent—said that the GMC should be responsible for that. The GMC has also been clear that it believes that it is capable of carrying out that regulatory function, and it has already begun putting arrangements in place to manage the process. It gave evidence to the committee, and we have met with it and discussed the matter.

I used to be regulated by the Health and Care Professions Council; it regulates a range of bodies and different professional groups, and I do not think that that causes confusion for the public. The idea of another regulator taking on an additional bit of regulatory work is not greatly difficult for the public to understand.

**Carol Mochan:** It is not that I disagree with that—I was just interested in knowing whether, given that that diverse group is already a whole regulatory body, it made sense for those roles to sit with the HCPC.

**Emma Harper:** I am going to declare an interest, too, as a registered nurse. I worked with physician assistants and what are now physician associates when I worked in a level 1 trauma centre in California, including in anaesthesia. Therefore, I have been interested in following this debate and, indeed, have looked at the American perspective. In May 2021, the House of Delegates passed a resolution to formally name physician associates as associates. I know that there are issues and concerns that the training of physician associates or anaesthesia associates might impede the ability of junior doctors to find time for their training. Has that been considered so that we can allay concerns that it might impact the training of our junior doctors?

**Michael Matheson:** That is a legitimate concern to raise. As I mentioned to Dr Gulhane, we are taking a measured and evidence-based approach to the use of PAs and AAs and where those will sit in NHS Scotland and our workforce development. Scott Wood can say a wee bit more about that, because it is important that we ensure that the important training environment for our junior doctors is not compromised. However, I believe that it can all be managed in a proper programmed way, with a clear sense of where we see the role of PAs and AAs sitting and where they can add value to our healthcare system. Scott, do you want to say a bit more about that?

**Scott Wood (Scottish Government):** Yes, of course.

Ultimately, investing in the PA and AA workforce should help us create additional clinical capacity across the system and therefore liberate doctors' time, which can then be invested in other activities, including supporting high-quality training opportunities for doctors in training.

Clearly, we must carefully plan the future growth of PA and AA roles to ensure that there is sufficient educational supervision capacity across the system to support those individuals alongside doctors in training. That will certainly be part of the discussion that takes place through the MAPs implementation programme board, which the cabinet secretary has referred to. We will ensure that any plans for growing those roles take account of the training needs of the doctors in training.

11:00

**Emma Harper:** I have another quick question about the scope of practice of anaesthesia associates. In my experience as an operating room nurse, anaesthesia associates would anaesthetise patients who were young, fit and healthy and who did not have additional comorbidities or, say, type 1 diabetes that was out of control. The scope of what the AAs were allowed to do was very structured and quite limited—they could conduct monitored anaesthesia care and would support consultant anaesthetists with sicker patients.

The workforce has been non-regulated for 20 or 30 years now. The regulation that we take forward is about safety and ensuring that everybody understands the parameters of the scope of practice. On its website, the Royal College of Physicians says that there are

"over 40 specialties across primary, secondary and community care".

It also says that the role of the physician associate is

"varied, dynamic and versatile",

and that they are

"medically trained generalist healthcare professionals".

Can you reiterate that this is about optimising the safety of patients wherever they are being looked after, whether in primary or secondary care or in the community?

**Michael Matheson:** Absolutely, given the role that some AAs and PAs play and the need for us

to have a statutory regulatory process in place. In my opening statement, I said that patient safety lies at the heart of this; it is about accountability for healthcare professionals in their roles and the important role played by PAs and AAs.

You mentioned, for example, the role that anaesthesia assistants can play in the theatre environment. It is important that they are accountable for how they manage that provision. Of course, they do provide those services under medical supervision, but it is important that there are clear lines of accountability and responsibility.

That is all the more reason for having a regulatory environment in which there is statutory regulation of those groups. It is in patients' interests as well as the wider healthcare system's interests for those roles to be properly regulated and clearly defined and for there to be clear accountability for any decisions or actions that those professionals take. They should be held to account in the way that other healthcare professionals are.

**Paul Sweeney:** I want to pick up on points raised by the Association of Anaesthetists in response to our call for views.

First, the association has highlighted the issue of distinction of registration. Although it welcomes the fact that AAs and PAs will have different registration numbers to distinguish them from doctors under GMC registration numbers, it is also calling for a register, either online or in print, that is separate and distinct from that for doctors in order to

"provide absolute clarity for patients and others accessing the registers."

It says that that

"is to protect everyone from accidental or deliberate misrepresentation. There is no legitimate reason that this could not be done with modern information technology systems."

Is the cabinet secretary sympathetic to that perspective?

**Michael Matheson:** I understand the concern. I will ask Nigel Robinson to say a wee bit more about the practical application of the process and how the GMC might address some of these issues.

**Nigel Robinson:** In terms of the modern IT infrastructure that you have mentioned, it is important to note that all the data will be held on a database by the GMC. In other words, there will be one database that will be searchable according to the individual professions. However, there will be a slightly different alphanumeric format or basis for the actual registration numbers of each profession. To all intents and purposes, it will appear as though there are separate registers.

**Paul Sweeney:** In that case, am I correct in saying that, if I were to search for an individual, I could search only one doctor's register? Would I then have to go to a separate webpage to search for physician associates and anaesthesia associates?

**Nigel Robinson:** You would be able to filter your search. This is a work in progress, and it is a matter for the GMC as part of its broader programme as to how it brings those groups into regulation once the legislation is in place. The GMC council cannot properly begin the process and cannot take those decisions until it has the powers to do so.

**Paul Sweeney:** Do you discuss the specification of such matters with the GMC, or is that matter entirely for the GMC itself?

**Nigel Robinson:** The GMC council makes the final decisions, but we work closely with the GMC's office in Edinburgh and its headquarters in London.

**Michael Matheson:** It is worth adding that the changes bring the GMC within the competence of the Scottish Parliament. Ultimately, therefore, the GMC will be accountable to the Parliament and to this committee if the committee believes that the GMC's approach is not consistent with what it thinks is the right way to do things. The committee will be provided with a direct route into the GMC, which has not been available previously.

**Paul Sweeney:** That is certainly an interesting point.

The Association of Anaesthetists has also raised concerns relating to the scope of practice. It highlights that there should be

"a national scope of practice for AAs both on their qualification and for any postqualification extension of practice. Any future changes to scope should be developed in conjunction with the regulator and should be agreed at a national level."

It believes that it should not be for individual health boards to determine such changes. Do you agree that that is an appropriate way forward? Do you have anything to say on that matter?

**Michael Matheson:** We are looking for the national board to take forward that work. I will let Scott Wood say a bit more about that, but we need to ensure that there is a consistent approach.

**Scott Wood:** The scope of practice for PAs and AAs will be specific to the individual healthcare professional in question. It will take into account the skills and knowledge that they have attained in the course of their initial training; it will reflect any constraints or limitations associated with the role in which they are deployed at a given point in time; and it will reflect the skills and experience that they

have attained over the course of their careers in the form of continuing professional development.

Given that PAs can be deployed in a wide range of healthcare settings, it is hard to draw firm lines in their scope of practice, so we need to create some flexibility. That said, we are very happy to look at what further guidance might be required, as the cabinet secretary described, to support organisations, supervisors, PAs and AAs in defining the scope of practice. Guidance on scope of practice has already been published by the Association of Anaesthesia Associates to support those discussions, and we understand that the Faculty of Physician Associates is currently considering producing similar guidance.

We will keep a close eye on the development of that guidance and keep it under review. We will consider what further action we need to take to supplement that guidance in order to deliver the once-for-Scotland approach to the deployment of the roles that we want to see across NHS Scotland.

**Paul Sweeney:** I appreciate your comments. Thank you.

**The Convener:** I thank the cabinet secretary and his officials for answering the committee's questions.

We move to agenda item 4, which is the formal debate on the affirmative instrument on which we have just taken evidence. I ask the cabinet secretary to speak to and move motion S6M-11668.

**Michael Matheson:** I have nothing to add.

I move,

That the Health, Social Care and Sport Committee recommends that the Anaesthesia Associates and Physician Associates Order 2024 [draft] be approved.

**The Convener:** I remind the committee that members should not put questions to the cabinet secretary during the formal debate and that officials may not speak in the debate. I invite members who wish to contribute to make themselves known.

**Sandesh Gulhane:** I am not sure whether I need to declare my interest again, but I shall do so. I am a practising NHS GP.

I have met the Association of Anaesthetists, the British Medical Association and the General Medical Council Scotland on multiple occasions to discuss physician associates and anaesthesia associates; I have a number of concerns about their roles. There is a really important point to be made when it comes to regulation: we cannot regulate a body if we do not know what people's roles are and what the scope of their practice is. "Supervision level" has not been defined. Is supervision on a one-to-one basis, a two-to-one basis or a three-to-one basis? The numbers could go on. In her questioning, Emma Harper spoke of the tightly defined role of an anaesthesia associate in the US.

Let us consider two issues. First, the fit and healthy patients whom Emma Harper spoke about are exactly the type of patients whom our junior doctors are required to deal with during their training. When junior doctors start their training, they cannot start by treating really complicated patients; they need to start by anaesthetising—obviously, with supervision—fit and healthy patients. That is really important. Therefore, there are impediments to training and, potentially, other issues.

I have also heard of—

**Ruth Maguire:** Will Dr Gulhane take an intervention on that point?

**Sandesh Gulhane:** I will take an intervention once I have made these points.

I have also heard of anaesthesia associates anaesthetising children. I am also concerned about how anaesthesia consultants know how to supervise and what their level of cover is when something goes wrong. They have never been trained in supervising anaesthesia associates.

**Ruth Maguire:** Sandesh Gulhane appears to be making an argument against physician associates and AAs, but we have heard that they have been practising for 20 years. The instrument is about regulation of those professionals. Is Dr Gulhane making an argument against having those professionals in the system?

**Sandesh Gulhane:** No—my argument is about the role of regulation. Of course, regulation is important and it must occur, but we cannot regulate what we cannot define. Scope of practice is a very important part of that regulation, as is supervision level. With regard to scope of practice, we know that there has been an expansion in what our PAs and AAs have been asked to do. I know of general practices that run almost entirely on the work of allied health professionals, which saves the practice money, but potentially provides a two-tier system and service to patients in remote and rural areas, where they will not, in the main, see doctors. With the expansion of that PA role also—

**The Convener:** Will Sandesh Gulhane take an intervention on that point?

**Sandesh Gulhane:** Yes.

**The Convener:** Are you arguing against multidisciplinary teams and not acknowledging the advanced practice specialties that nurses and AHPs have, which, at times, allows them to

provide better and more appropriate care to patients in their practices?

**Sandesh Gulhane:** No—and the work that I do with my MDT, including our pharmacists and nurses, is absolutely vital. In fact, my practice nurse handles diabetes better than I do, because it represents is a lot of what she does. However, my argument is that, instead of looking to get doctors into practices, we are seeing expansion of the PA role, and thereby creating that dichotomy.

I have also heard of reports of PAs setting up privately and saying that they can offer all the same services. It is difficult to regulate if we cannot define the supervision level or the scope of practice. They have to be very tight and defined, in the same way as the situation that Emma Harper spoke about when we were talking about what happens in the US.

**The Convener:** Thank you.

**Emma Harper:** I want to clarify that, in my experience in the US, the area is very regulated. I described the fit and healthy patient: the American Society of Anesthesiologists uses a classification of 1 through 4 for patients' fitness to undergo anaesthesia. That system is already in use in this country. It has been a long time since I worked in the operating theatre for seven years, but we use that classification so that junior doctors can assess patients, and then a registrar or a consultant might, for instance, do anaesthesia or surgery after the patient safety assessment.

Therefore, the associates are already working within a scope of practice. There are lots of different specialties among physician associates in the community or in general practices. What we need to be careful about is that the instrument is about regulation—in an area where there has been an absence of regulation—so that we can promote safety for patients, no matter where people are working.

11:15

I have worked in departments in which care is led by a team of people with different job scopes. Everybody knows their role and it works absolutely fine. Ultimately, in that team environment, the physician—the surgeon—who is a consultant, would have that "The buck stops here" ability to direct care. I am interested in the whole issue of supporting our PAs and AAs to practise and to develop their scope, but I do not think that we are suggesting that PAs and AAs will be calling themselves doctors.

**The Convener:** Thank you, Ms Harper. If that is all from members, would you like to sum up and respond to the debate, cabinet secretary?

**Michael Matheson:** I have listened very closely to the issues that have been raised by members of the committee on this matter. Ultimately, we should keep in mind that this is about helping to promote patient safety. For example, as things stand, PAs—even PAs who set themselves up in private practice—are unregulated. My view is that they should be regulated, and that we need to be clear about the terms of that regulation.

It is also worth keeping it in mind that most health regulators do not operate by setting out a scope of practice. They supervise or deal with issues on the basis of whether someone is within the scope of their competence in their role. People progress through their careers and gain greater experience and understanding and, as a result, they should be operating within the scope of their competence at that particular point. That regulatory process operates across healthcare professions.

Additionally, aspects such as supervision are dependent on experience and skills. A person who moves into a new area where they have less experience and knowledge might be put under increased supervision in order to achieve that experience and knowledge. Therefore, the issue of scope of practice is one that the regulators already deal with. They deal with it in terms of whether a person goes outwith the scope of their competence and their practice ability. Supervision is very dynamic—it is very dependent on the environment and on the person's skills and their needs at that particular point.

When I first qualified, my level of supervision was greater than it became as I moved through my career, which reflected the experience and knowledge that I had built up. My regulatory body would expect that to happen on the basis of my competence.

PAs who are used in general practice are, right now, outwith the scope of the direction that we have set as the Scottish Government, because they can be directly employed by a general practice to be deployed in a way that the practice sees as being most appropriate for its needs. We are not able to give direction on that, as we can within the NHS. Again, that is why PAs should be regulated.

The key thing is that the GMC is undertaking a process to ensure that PAs and AAs are appropriately regulated. I do not think that it is in the interests of patient safety that those professional groups—which are already operating in our healthcare system—remain unregulated. In my view, the order will enhance patient safety and enhance accountability, so it is critical that it is passed today by the committee.

**The Convener:** Thank you, cabinet secretary.

The question is, that motion S6M-11668 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**For**

Harper, Emma (South Scotland) (SNP)
Haughey, Clare (Rutherglen) (SNP)
Mackay, Gillian (Central Scotland) (Green)
Maguire, Ruth (Cunninghame South) (SNP)
McKee, Ivan (Glasgow Provan) (SNP)
Mochan, Carol (South Scotland) (Lab)
Sweeney, Paul (Glasgow) (Lab)
Torrance, David (Kirkcaldy) (SNP)

**Against**

Gulhane, Dr. Sandesh (Glasgow) (Con)
White, Tess (North East Region) (Con)

**The Convener:** The result of the division is: For 8, Against 2, Abstentions 0.

*Motion agreed to,*

That the Health, Social Care and Sport Committee recommends that the Anaesthesia Associates and Physician Associates Order 2024 [draft] be approved.

**The Convener:** That concludes consideration of the instrument. At our next meeting, we will be taking evidence on the draft funeral director code of practice 2024 from the Minister for Public Health and Women's Health.

11:20

*Meeting continued in private until 12:51.*

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