OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 6 March 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 6 March 2018

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HEALTH AND SPORT COMMITTEE
8th Meeting 2018, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Ash Denham (Edinburgh Eastern) (SNP)

COMMITTEE MEMBERS

*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Jenny Gilruth (Mid Fife and Glenrothes) (SNP)
*Emma Harper (South Scotland) (SNP)
*Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*David Stewart (Highlands and Islands) (Lab)
Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Syed Ahmed (Health Protection Scotland)
Dr Peter Bennie (British Medical Association)
Paul Buckley (General Medical Council)
Mark Dayan (Nuffield Trust)
Dr Donald Macaskill (Scottish Care)
Joanna Macdonald (NHS Highland)
John Watson (ASH Scotland)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 6 March 2018

[The Convener opened the meeting at 10:00]

Subordinate Legislation

National Assistance (Sums for Personal Requirements) (Scotland) Regulations 2018 (SSI 2018/41)

National Assistance (Assessment of Resources) Amendment (Scotland) Regulations 2018 (SSI 2018/43)

Personal Injuries (NHS Charges) (Amounts) (Scotland) Amendment Regulations 2018 (SSI 2018/47)

The Convener (Lewis Macdonald): Welcome to the eighth meeting in 2018 of the Health and Sport Committee. We have received apologies from Sandra White. I ask everyone in the room to ensure that their mobile devices are switched off. I also ask you not to record or film the meeting; that will be done by the Parliament.

Item 1 is subordinate legislation. We have three instruments to consider under negative procedure. No motions to annul have been lodged, and the Delegated Powers and Law Reform Committee has not made any comments on the instruments. Does the committee agree to make no recommendations on the instruments?

Members *indicated agreement.*

Leaving the European Union (Impacts on Health and Social Care)

10:02

The Convener: Our second and main item of the day is evidence on the impact of leaving the European Union on the health and social care sector in Scotland. In this evidence session, we will consider a number of areas in which it impacts on the general public and on access to health.

I welcome Mark Dayan, who is a policy analyst for the Nuffield Trust, Dr Syed Ahmed, who is the clinical director of Health Protection Scotland, and John Watson, who is the deputy chief executive of ASH Scotland. We have a number of questions for the witnesses. I invite Ivan McKee to open the questioning on the impact on public finance.

Ivan McKee (Glasgow Provan) (SNP): I thank the panel members for coming along to talk to us about what is obviously a critical issue. We value your insights. The area that I will focus on is the potential for public funding challenges for the NHS.

If you look at the assessments that have been done by the United Kingdom Government and by the Scottish Government on the impact of Brexit, it is clear that they range from a complete disaster to an utter meltdown in terms of the impact on the economy, depending on the scenario that we end up with. Over the next number of years, that could have a significant impact on the funding that is available for public sector finances. Do you have any thoughts on that, any data that you can share, any comments on how that might play out or any fears about what we might see unravelling in the years after Brexit?

Mark Dayan (Nuffield Trust): What you say is quite right. There have been a large number of different estimates on different timescales. Perhaps the clearest estimate of the impact on public finances is from the Office for Budget Responsibility in London, which sets the UK Government's expected income for future years. It thinks that there will be about £15 billion less in the Treasury by 2020 as a result of the UK leaving the European Union.

When you go a bit further out, into what might be thought of as the medium term, to 2030, the estimates start to diverge much more sharply, as you have probably seen—they show anything from 2 per cent to 6 per cent less than we might otherwise have had in the economy at large as a result. You would expect that to feed through, more or less one for one, into the public finances as well.

The estimated impact ranges from substantial to really serious. Unfortunately, there is not as clear a correspondence in the studies as one might expect between softer forms of Brexit and a reduced economic impact. However, on balance, I would still expect that to be the case.

Ivan McKee: Can you put some colour in the picture of the impact that public sector funding cuts of that level could have on the health service, given that, over the years, we have become used to health service funding increasing by more than the rate of inflation? What would that look like for people?

Mark Dayan: I would not expect it to result in outright cuts. We are still talking about a growing economy and, therefore, a tax base that would be growing. However, we are talking about less of an increase than is currently expected.

As you say, we have just been through several years in which health funding has been held near to flat, while demand and the pressures of medical technology have seen a greater call on funding, which has risen more quickly. That has resulted in a wide range of pressures including, but not limited to, problems with waiting times, pressure on wages—which has contributed to difficulties in recruiting staff—and difficulty in adopting the latest medical technologies. Unfortunately, in so far as Brexit prolongs the period in which we are unable to return to the historical trend of an increase in funding of about 4 per cent a year, it is to be expected that it will prolong the period in which those things are the reality that we face.

Ivan McKee: Thank you.

The Convener: One of the most visible impacts on the public of leaving the European Union might be access to healthcare outwith the United Kingdom. David Stewart has a question on that.

David Stewart (Highlands and Islands) (Lab): I want to ask about reciprocal healthcare. We know that the jewel in the crown is the European health insurance card. More than 27 million UK citizens have such a card. How important is the card for EU citizens and for UK citizens, in particular? What would be the effect of losing that reciprocity?

Mark Dayan: The EHIC is quite important, and there are two levels to the value that it delivers as an initiative. As we all know, people can use the card as a form of travel insurance when they go on holiday, to supplement private travel insurance. That is also helpful to business travellers. From that perspective, the card helps to smooth travel and tourism across the UK and the EU. In doing so, it also contributes to people's ease and enjoyment as consumers, holidaymakers and travellers, and it probably contributes to the tourism industry and other service industries that involve going back and forth.

A minority of people require quite intensive and regular healthcare support such as dialysis. The scheme makes it possible for them to travel and be sure that they will be able to access, for example, weekly dialysis abroad when the costs of doing that through private insurance would be prohibitively huge. The card provides substantial benefits.

In terms of finance and the scale of impact on many people's lives, one might argue that the scheme that is known as S1 is more significant. As the committee may know, that is the scheme under which people can work in one EU country and retire to another with many of the benefits that they might get as a pensioner, including healthcare, intact. Many UK citizens have availed themselves of the scheme, usually in order to move to southern Europe, and the scheme provides the basis of their healthcare coverage. Such citizens are often older people, so it is an important issue for them.

We hope that that issue has been dealt with in the withdrawal agreement, assuming that it is successfully passed as a treaty between the UK and the EU. However, future access to EHI cards by people who are not already in another country would have to be sorted out through the future relationship and, unfortunately, there is no precedent for that outside the single market.

David Stewart: Thank you for that answer, which anticipated my second question, which is on the S1 scheme. I am concerned about the possible loss of S1. If someone has moved to Spain, Portugal or Italy and they are well established and perhaps getting on in years, they will be using the S1 scheme for on-going healthcare. Has any estimate been made of the effect on the British national health service of returning UK citizens who are currently living abroad? Has there been any assessment of the hit that that will have on our primary care services?

Mark Dayan: Yes. We did a calculation that looked at the relative cost of each pensioner receiving care under S1 in another EU country compared to their being in the UK. The estimate, which was surprisingly high, was that it would cost around £500 million more to care for those people in the UK—and that was assuming the rates of the English NHS, which are slightly lower than those of the Scottish NHS. It would also potentially require an extra 1,000 hospital beds. Given that, as I am sure many of you know, the NHS across the UK is in a period of real squeeze on bed space, those beds would not be easy to bring on stream.

That would introduce an extra level of uncertainty and risk for services in the UK, which would obviously have a duty to provide for those people, because they have a right to receive healthcare here. The withdrawal agreement that was reached last December and the legal text that the European Union has produced as a basis for turning that into a treaty say that, at least for people who already have S1 and EHIC cover, those issues should be dealt with—people who are in a cross-border situation on exit day should be able to retain the rights that they currently enjoy.

David Stewart: So, the impact may well be on people who are currently thinking of leaving the UK to stay in an EU country. Brexit may affect their ability to move, because they may not get healthcare or, indeed, social care in the future.

Mark Dayan: That is absolutely right. That forms part of a wider set of issues around the free movement of people after Brexit. It may not merely be that people will not be able to access healthcare if they go to Spain; they may simply not be allowed to go. That would have implications, gradually, for the demographics that the NHS is addressing.

David Stewart: Going back to the European health insurance card, you have touched on the subject of my question. Macmillan Cancer Care gave evidence to the House of Commons Health and Social Care Committee and said that it is very concerned about the implications of the withdrawal of the EHI card for people who have cancer or, indeed, any serious illness. If we lose that card and people have to take out very expensive private travel insurance, is there a real possibility that people with cancer, mobility problems or serious illnesses will, in effect, be restricted from travelling within the EU in the future?

Mark Dayan: It is hard to see how that would not be so in at least some cases if there was no replacement for the EHI card to provide some sort of subsidy.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): My questions follow on from David Stewart's questions on the EHI card. The Nuffield Trust has not provided a written submission for today's meeting, but, in its submission to the Health and Social Care Committee's inquiry in 2016, it said:

"There is also a risk that without S1 and EHIC, more unwell British citizens facing high private insurance premia would return to the UK to exercise their right to free health care, effectively cancelling out significant proportion of any savings."

The Community Pharmacy Scotland submission that we received argues:

"The biggest risk that the Scottish Health and Social care system faces in this respect is that there is no transitional period or that current EHIC arrangements are not adopted into domestic law in time for March 2019. This would leave Scottish citizens (both with and without existing healthcare conditions) vulnerable when travelling in EEA member states."

It suggests:

"This risk could be mitigated by having a transitional period wherein either the relevant legislation is transposed or new, similar arrangements are made (preferably the former)."

It argues for that transitional period to be in place; however, I understand that that is not currently the case. What is the panel's view about there being a transitional period in the meantime with regard to the EHIC provisions?

Mark Dayan: It might be a bit generous to call the current situation a plan, but the expectation is that there will be a two-year transition period between March 2019 and roughly the end of 2020, as the UK leaves the EU. During that period, the entire body of EU law will be rolled forward and will continue to apply. To simplify a bit, that will, in many ways, be like remaining a member of the EU but without voting rights. That effective continuation of membership will apply to the EHIC and S1 schemes as well as anything else.

What those submissions, including ours, are possibly getting at is that it is certainly not a done deal that that will happen. It relies on our signing the treaty at the end of this year or the beginning of next year, having come to agreement on some of the difficult issues that remain. As long as we reach that position, the current plan is that a transition period will apply to EHI cards.

Jenny Gilruth: Healthcare is largely a devolved matter, and Community Pharmacy Scotland goes on to say that

"it is inappropriate that reciprocal healthcare is dealt with using a common framework following Brexit. It is difficult to comment without speculating, but whilst any arrangement would likely mirror Westminster's initially, the devolved nations must have the freedom to pursue relationships with individual countries independent of one another."

Do panel members have a view on that?

Mark Dayan: That is an interesting thought. There is a sense in which it has proven very difficult to negotiate reciprocal healthcare agreements outside the EU. We do not have agreements with that many countries non-EU countries—Australia and New Zealand are about it. We used to have them with some countries in the Balkans, but those have lapsed. It might be quite challenging to reach any agreements, and from that point of view the UK as a whole might be the unit that has the easiest time in doing it. Whether, as part of those agreements, we could leave room for variants based on what the devolved countries want is an interesting question.

10:15

Jenny Gilruth: In your submission from 2016, you go on to say:

> "Developing a full set of separate arrangements with EU members would be a formidable task",

but, as you say, that has been done with Australia and New Zealand, so it is not impossible.

We are interested in the powers of this Parliament. As health is one of them, it is important that we look at how the powers that are coming back to the UK are devolved back to the respective nations within the United Kingdom.

Mark Dayan: Yes, whether they can be brought back in a devolved sense is a very interesting question that applies to many aspects of healthcare.

The tricky element of reciprocal healthcare is that our current arrangement with the EU is funded through Westminster and derives from treaties that were signed at Westminster, although that is not to say that any treaty that is made cannot have written into it a role for devolved Governments in varying it.

The Convener: Thank you. Do any other witnesses have a view on whether Brexit will have any potential benefits for the promotion of public health policies in Scotland? Are there aspects of leaving the European Union that create opportunities to do things that have not yet been done?

John Watson (ASH Scotland): There are certainly opportunities that come from Brexit. The work that we do is largely about regulating commercial entities that produce harmful products. The importance of trade deals for us is that they set down some kind of balance between the rights of companies to produce, distribute and sell their products and the rights and powers of Governments to regulate that activity and interfere in the market.

As part of the European Union, we are signed up to a body that is largely focused on having free movement of goods between its member countries. That places some limits on the ability of Governments to put restrictions on particular products, because that would restrict the ability of companies to move those products between member countries.

For example, the Scottish Government is interested in banning plastic drinking straws. To do that, the European Union has to be notified. Then there is a period during which other countries can say that they think that a ban would have an impact on their companies and is an unreasonable restriction on trade. There are hoops that need to be gone through before a domestic ban can be pursued.

The same is true for projects for regulating tobacco that we would like to see taken forward in Scotland. There are many more avenues that we have to pursue to achieve properly regulated trade in what is the most harmful consumer product around. Plastic straws can be taken as an analogy for cigarette butts. The most common form of plastic waste on our streets, on our beaches and in the sea is not drinking cups or plastic straws; it is plastic cigarette ends. They do not bring health benefits, but we would like to bring that issue into the discussion. However, to do that would mean going through various hoops in terms of the European Union.

Although efforts to bring about restrictions on the sale of a product can be taken forward while we are a member of the European Union, Brexit will make that easier because there will be fewer hoops to jump through.

Dr Syed Ahmed (Health Protection Scotland): I have nothing to add other than to say that maintaining health protection and health security requires close collaboration with our partner agencies. Anything that would interfere with that collaboration and co-operation is not good for health protection.

Alison Johnstone (Lothian) (Green): I had wanted to ask a similar question to yours, convener. However, I will ask about the need to tailor regulations to the Scottish context. Let me give an example. Community Pharmacy Scotland has said in evidence that we received that, as opposed to following a common framework, Scotland needs to ensure that health-related powers that return to Westminster from the EU are devolved, as our public health services are already at a more advanced stage than those in the other home nations and development would suffer if it was necessary to pursue UK legislative change to allow further innovation. I would like to understand the panel's views on the need for Scotland to exercise those powers over health, post-Brexit.

John Watson: I can summarise our interest with a simple phrase: we believe that Governments need to retain the right to regulate harmful products that are sold by companies. That is a very good example of an area in which Governments need to interfere in the free market. If it was simply a matter of the UK leaving the European Union, we would probably be quite confident about the way in which that interest would be taken forward, because there have been some fairly proactive policies in all the constituent parts of the UK—particularly in Scotland—in terms of robustly interfering in the market in pursuit of public health goals. If it was simply a matter of deciding how we would do things domestically when we left the European Union, we would be quite confident that this Parliament would continue

its fine tradition of engaging with the market and trying to achieve better goals than the market would achieve if it was left to itself. I am very pleased that powers will come to this Parliament, where they have been very well used in the past.

The other side of the coin is that the UK will enter into an entirely different set of international trade deals in which there will probably be an emphasis on free trade. The balance might shift again once that happens, and we are concerned that the pendulum might swing back too far and that the opportunities to regulate and interfere in the market will be traded away in order to get a wider trade deal.

Alison Johnstone: Do other witnesses share those concerns?

Mark Dayan: Yes. I certainly think that it is possible that some of the freedom of manoeuvre that will potentially be granted by Brexit could be removed, either through trade deals with third countries or through the trade deal with the EU itself. According to current plans, the deal with the EU will be a very deep trade deal, which will likely make the EU want to ensure that there is a level playing field and that the UK does not have rights to deregulate, which is what the EU fears.

To build on what John Watson said, I think that there are certainly areas in which it is worth looking at Scotland having a separate, devolved set of policies, such as on aspects of public health. I also cannot see any reason why Scotland could not go its own way in areas such as procurement once those powers come back from the EU.

I caution that there are some areas in which there is a genuine argument for a common framework across the UK. On human tissue regulation, for example, the European Union's harmonisation of how things such as blood and organs are dealt with has facilitated, to some extent, those who move across borders within the EU to address pressing medical needs. It would be a great shame to lose that harmonisation with the rest of the EU but, if we do, I certainly would not want to lose at least the ability to move organs between Scotland, England and Wales. In that example, I can see scope for some level of co-operation to ensure that there can still be ease of moment around the UK, in what are often time-pressed and difficult situations.

However, in other areas—and there is a principle to consider here as well—it is worth considering how some of the powers that will be brought back could be devolved to Scotland so that it could go its own way in some matters.

Alison Johnstone: To be clear, does the panel think that there could be potential risks to public health in Scotland, particularly if we pursue a hard Brexit with an emphasis on deregulation?

Dr Ahmed: Yes.

John Watson: Absolutely. A hard Brexit that gave additional rights and freedoms to commercial companies would put real restrictions on the Government's ability to take forward public health policies. For example, recently there were negotiations between the European Union and the United States on the transatlantic trade and investment partnership, which was of great concern to us. It opened up whole new areas of rights for companies to demand access to markets. It is of great concern to us if tobacco companies, for example, are able to demand access to markets. In the recent example in the UK's domestic courts, it was quite galling to see tobacco companies using the European convention on human rights to oppose public health measures. I feel that rights to property should be available to individuals, but it is wrong for companies to claim those rights for themselves, and use them as the basis for attacking and challenging Government policies that try to limit tobacco advertising. I do not want that prospect to come up in future trade deals.

The Convener: Thank you. We will move on to future trade deals, on which Ash Denham has some questions.

Ash Denham (Edinburgh Eastern) (SNP): Some of my questions have been answered in response to Alison Johnstone's question. As has just been mentioned, the UK Government wants to pursue common frameworks in order to facilitate potential trade deals. At the moment, however, the devolved nations have had very little input into the process, so there is a potential risk there.

Another risk is the investor-state dispute settlement clauses, which would allow corporations to sue Governments that were pursuing legislation, potentially in the public health arena, that the corporations thought would interfere with their profits. If such clauses were included in a future trade deal, there would be quite a risk to public health in Scotland.

There is much less private provision in the Scottish health service than in the English NHS. If, therefore, the Scottish health service included itself in a trade deal, we would see that as a risk to the principles of the NHS. Should the Scottish NHS be excluded or exempted from any future trade deal?

Mark Dayan: You ended on an important point. There are often a lot of concerns about things such as investor-state dispute settlement systems. To my mind, all that they do is enforce the terms of trade deals, and domestic courts would be likely to enforce them in a similar way. The real issue is what you signed up to in that trade deal in the first place.

As you say, the English NHS is much more marketised and has a greater role for private providers. That is very much a live issue because the relationship between the UK and the EU means that the English NHS has to be fully open to market-based tenders for anything for which it provides an internal contract, which is nearly everything. There is therefore a very live question about whether that will remain the case under future trade deals with the EU or, indeed, with other countries.

In considering whether the Scottish health service will be part of that, you have to start by recognising that the Scottish health service works very differently, in that it does not have internal contracts. In many cases, there is nothing there for which a private company could claim that it would be able to tender. That said, within international trade deals, it is certainly possible to limit the sectors or institutions that are covered. For example, you could say that Scottish health boards are not subject to the trade deal. There is an element of that in the recent Canada-Europe trade agreement.

The important thing is what is written in the trade deal. There is a place there for exemptions, including exemptions at the level of bodies that are Scottish within a UK context. For example, some Canadian states and territories are not included in the Canada-Europe deal. Such things are possible, and they have important implications at the Scottish level, as opposed to at the UK level. It would make a lot of sense for the Scottish Parliament and the Scottish Government to have some input to that.

Ash Denham: Does the rest of the panel agree with that?

John Watson: Yes. On the importance of what someone is signing up to when they sign up to a trade deal, we have seen deals negotiated that have included rights for companies to sue Governments when they enact or propose to enact legislation that would impact on their profits.

That brings it all home to us very strongly, given the business that we are in. The Scottish Government has set a target for reducing the overall rate of smoking and the amount of tobacco that is consumed in Scotland, and it has cross-party support for that. However, that policy is in direct opposition to the profits of the companies involved. The Government's target is not about changing the way in which the company operates and it is not about having it sell different things; it is just telling the company that it wants it to sell less of a particular product. You could have an absolutely legitimate public health policy that could come up against that kind of trade agreement. If the companies had the right to sue the Government for enacting legitimate health policies, it would be a disaster for public health.

Dr Ahmed: From a health protection point of view, most of the preventative services—screening, immunisation, dealing with major outbreaks and so on—are mainly funded by the Government. There is limited scope for the private sector to go into those arenas.

10:30

Alex Cole-Hamilton (Edinburgh Western) (LD): Picking up on Ash Denham's point, I think that, since the days of the general agreement on trade in services and the negotiations around the World Trade Organization treaty, it has been clear that America in particular has often looked with hungry eyes at the NHS and the services contained therein as a potential emerging market. It is clear from the isolationist and protectionist policies that the Trump Administration is beginning to adopt that a trade deal with America will be incredibly hard without some sweeteners. What would happen if Teresa May's Government capitulated on the idea that the NHS is not for sale and parts of the NHS went up for sale to American providers or were opened up wholesale to American companies? What would be the negative consequences of that and of the potential for a race to the bottom in terms of provision from aggressive American companies? Of course, that would be in addition to the points made by John Watson about the potential for litigation by companies that thought that their profits would be affected by Government policy.

Mark Dayan: It is worth looking at that from the point of view from which the English NHS starts. It is already the case that, under EU law, England's marketised system must be fully open to private companies. It is not that that is something that could happen in a future trade deal, because it is already very much the starting position. It would not be a change if that were to occur, because that is where we have begun. Without wanting to cast judgment on the entire English marketised system, I believe that a significant number of people in the leadership of that system would say that, quite apart from anything else, it results in a lot of paperwork and a significant amount of additional work. That is because most contracts for services need to be put out to an open tender, when it is fairly obvious in many cases that the local NHS hospital is the only body that can really provide those services. That level of extra process and bureaucracy is not always welcome.

Although that issue may well come into a trade deal with the USA, it will first come up in the trade deal with the European Union. The European Union has made it quite clear that it wants what it calls a level playing field, where the UK is not

allowed to deregulate or to start subsidising its companies more. There is at least a chance that that will include the EU not wanting the UK to close access to public procurement.

Our starting position is therefore that the market is quite open to international companies coming in and providing services—in England, at least. Scotland is protected from that simply by the make-up of its health system and the fact that it does not have an internal market. That is the starting position, and the first fork in the road in terms of whether we keep that protection will be the trade deal with the European Union itself.

Alex Cole-Hamilton: Do other panel members want to comment?

Dr Ahmed: It is not a very relevant issue for Health Protection Scotland.

The Convener: Do any of the witnesses have evidence of active engagement by, for example, tobacco companies or health providers in the commercial sector, in relation to trade deals negotiated by the European Union while we have been a member?

John Watson: We certainly know that tobacco companies are very active in lobbying. For example, the recent European Union tobacco products directive was the subject of absolutely vociferous lobbying, with hundreds of people employed by the tobacco industry around Brussels at the time of those negotiations. We obviously do not know what they were saying or what they were doing in terms of their engagement with the decision makers, but we know that international trade is something that they see as absolutely paramount to their business interests.

Internationally, tobacco companies have taken forward legal challenges under a host of other trade agreements. When the Australian Government introduced standardised packaging for tobacco products, a challenge was taken to the World Trade Organization. When Uruguay brought in pictorial health warnings on packaging, that was challenged under an international trade agreement as being a barrier to trade. We know that the tobacco industry is focused on such challenges, and that has real potential to restrict public health interventions.

The Convener: Are there examples of cases where such interventions and lobbying have been successfully challenged and the measures upheld, or have countries' ability to set terms of trade for public health reasons been limited by them?

John Watson: Generally, we know that the companies tend to lose the court cases, but we have to accept that there are two reasons why they would bring them. One is that we are never quite sure what a judge or a panel is going to come up with, so if someone has deep pockets and lots of lawyers, it is always worth a go. The other is that it is expensive and time consuming for Governments to defend such challenges. The Scottish Government spent several years in the courts defending minimum unit pricing of alcohol. That has the knock-on effect of discouraging Governments from trying to do anything new and innovative that may leave them open to challenge, even if they think that they will win the challenge in the end. Not many civil servants feel that they have the time and energy to spend years in the courts trying to defend something that has already been passed democratically, so there is a real disincentivising effect.

The Convener: Thank you. We will move on to talk about surveillance of communicable diseases and other health protection matters, with Emma Harper.

Emma Harper (South Scotland) (SNP): Good morning, panel. I am interested in communicable diseases and the issues around cross-border threats to public health, which are currently monitored by the European Centre for Disease Prevention and Control in Sweden. Our issues paper says:

> "The ECDC runs systems for the surveillance and early detection of communicable diseases which facilitates prompt sharing of information and expertise when required, for example in relation to pan-European responses to the H1N1 'swine flu' pandemic and efforts to tackle anti-microbial resistance."

When we manage influenza outbreaks, it is crucial that countries work together. According to the Community Pharmacy Scotland submission,

> "It is essential that the UK remains a part of this process, or the health of the public will be placed at risk."

I am not suggesting that there will be a mass apocalyptic zombie flu outbreak when the UK leaves the European Union, but what mechanisms might be put in place for sharing information and expertise on communicable diseases and cross-border threats so that we can protect the public? I am interested in what conversations are happening now to protect people in the future.

Dr Ahmed: You have raised a number of issues. The important thing is that the ECDC gets the data from individual member countries. We already have a very effective surveillance system in Scotland and we feed the information through Public Health England to the ECDC, which collates the information for all the EU countries. As you correctly say, there is an alert system whereby it alerts us.

There are two points in relation to that. First, over and above the ECDC, information on things such as flu pandemics and swine flu is co-ordinated by the World Health Organization, and

the international health regulations, which will remain in place, automatically alert all the WHO member countries of any emerging new virus that might cause a pandemic.

Secondly, we also work closely with the ECDC, which does risk assessments. Public Health England is the national focal point for the whole of the UK, so we work with the ECDC through it. Public Health England has just set up a group to look at the implications of Brexit regarding surveillance and our ability to respond to any major outbreaks.

When we look at each individual element, as long as collaboration and co-operation continues with European countries through the ECDC—and there is acknowledgement that disease does not recognise boundaries and borders—there should not be any major issues. We are looking at the mitigating factors that we need to put in place to be able to respond.

On the whole, in the UK and in Scotland particularly, we have a very good and robust system of identifying, managing and responding to outbreaks. Quite often, I am pleased to say, a lot of the EU countries look to the UK public health system for support and learn lessons from us.

Emma Harper: Norway, Lichtenstein and Iceland participate in the European Centre for Disease Prevention and Control, but they are not full members. They still have to pay, but they are without a vote. Is that what the UK will do? Will it buy into the centre without having a say in how things are managed?

Dr Ahmed: I do not know exactly what arrangement the UK Government might have with the ECDC, but our main interest should be in sharing intelligence both ways and in continuing collaboration between the scientists and others who have been doing a lot of research and so on. I am not sure whether for Britain the idea is to purchase anything from ECDC. We are not looking to purchase anything, because, as I say, with regard to the surveillance system, we give it the data and it produces an EU-wide database. There is nothing that we do in health protection that requires us to buy anything from ECDC. The important issues are continuing collaboration and sharing intelligence, data and so on.

Emma Harper: So, there will be no zombie apocalypse.

Dr Ahmed: I hope not.

The Convener: Emma Harper's reference to some of the countries outwith the EU that are full participants in the ECDC parallels the discussions around whether the UK should be in the single market in trade terms. Is there a direct connection between the two issues, and how would that potentially work? In other words, from your knowledge of working with colleagues in Norway, for example, are they, in professional and practical terms, full participants alongside colleagues from the UK and other countries?

Dr Ahmed: That is my understanding. Further, colleagues from Switzerland—which is not party to the sort of agreement with the EU that Norway is—sit on the UK expert committee on vaccination and immunisation, because they have special expertise, and we sit on Switzerland's committee. I do not think that being a full member of the EU either helps or negates that kind of close scientific co-operation between professionals.

Mark Dayan: To some extent, I share Syed Ahmed's optimism, which is based on the fact that there is good joint working in place already and that it is in people's interests for it to continue. However, I would add a slight warning note, in that all the countries that are being mentioned in that regard—Norway, Iceland, Liechtenstein and Switzerland—participate in the single market, abide by EU law and pay into a wide range of EU funds, which means that, in some ways, they have a closer relationship with the European Union than the one that we are currently on track for.

Emma Harper: The idea that Dr Ahmed talked about with regard to the sharing of intelligence and information sounds all very altruistic and unselfish, but someone has to pay for people to transfer from London to Switzerland for meetings and so on. I assume that, at the moment, that would require input from the UK Government.

Dr Ahmed: Yes. At the moment, we have to be mindful of the fact that ECDC organises various scientific conferences and meetings involving all the EU countries, and the costs of scientists from Scotland and other UK countries attending those meetings are quite often paid for by the ECDC fund. Public Health England and ourselves need to think about the implications for the availability of funding after we leave the EU, so that we can ensure that doctors and so on can go to those conferences and meetings without any hindrance.

Another source of funding that is accessed quite often is the research funding from the horizon 2020 programme. Obviously, the EU has a big research fund, and our staff apply for research funding on various topical health protection areas. Currently, we are looking at the implications of an inability to access that funding. We must ensure that appropriate mechanisms are available for our scientists to access it.

The Convener: You mentioned that Public Health England acts as the focal point in relation to communicable disease control. We will have a few questions in a moment about common frameworks but, first, can you describe how that

relationship works currently? In other words, does Health Protection Scotland have members on the working group in Public Health England? Is there a formal or informal working arrangement?

Dr Ahmed: There is a formal arrangement. We have regular meetings with Public Health England. For example, there is a four-way teleconference between the four UK countries every two months, which involves the medical director of Public Health England, at which we discuss issues that affect the UK countries.

Because infection and disease do not recognise boundaries and borders, we talk to Public Health England almost daily. For example, this weekend we dealt with a case of hepatitis A involving a person from Scotland who went to Spain and came back, and we communicated with Public Health England and the Spanish authority to give them a list of contacts who required urgent treatment such as vaccinations. That sort of co-operation happens daily.

10:45

The Convener: Is the co-operation governed by a formal arrangement?

Dr Ahmed: Yes. For some services, such as chemical and radiation responses, we do not have the capacity in Scotland, so we buy it in from England's Centre for Radiation, Chemical and Environmental Hazards. The response to the poisoning of the Russian dissident last night was led by the CRCE. If something like that happened in Scotland, we would look to the CRCE to support our response to the incident.

Brian Whittle (South Scotland) (Con): Good morning, panel. I am interested in the discussion about common UK frameworks after Brexit, and the likelihood that a number of policies will fall within the legislative competence of the devolved institutions. What are the key priorities for those frameworks, given that the UK Government is currently subject to EU law, many areas of the health and social care market will fall within devolved competence and effective dialogue between the UK Government and the devolved Administrations will have to continue?

Mark Dayan: Although I look at Brexit and the NHS, I am not an expert on devolution, so I do not necessarily have an expert's view on what would be covered by common frameworks or what might be expected to return to the Scottish Parliament.

That said, although this is a live issue in some areas of health regulation, it is perhaps less so than you might first think. The fundamental point is that health does not fall within EU competence. A lot of powers have always resided with the Scottish Parliament, as part of its general powers over health, and some major areas of EU action on healthcare, such as medicines regulation and professional qualifications, are already reserved powers in the UK context.

However, around the edges of health and social area, there are likely to be key powers coming back from the EU that might be expected to sit with the Scottish Parliament but which might be retained by Westminster through common frameworks—although I suggest that you ask someone who looks closely at devolution law. Those powers might include working time, which is a live issue in medicine, the regulation of clinical trials and aspects of science, the levying of public contracts and, potentially, some areas of tobacco and public health regulations, about which John Watson will know more than I.

John Watson: We have seen regulation of tobacco: recent examples are standards for electronic cigarettes and mandatory picture health warnings, and a ban on menthol cigarettes is coming up. I believe that those will all be taken forward after Brexit, although there may be discussion about electronic cigarette regulation.

For new regulations, our view is that it is important to maintain the flexibility and innovation that have come from different areas. For example, the tobacco retailers register that was set up in Scotland has been picked up by other parts of the UK. Sometimes an Administration has put forward a policy that has not done so well and has not been picked up by other areas. The important thing for us is to maintain that innovation; we have not had a great need for common frameworks, because if an idea works well, it will be picked up by others.

Brian Whittle: How should stakeholders be involved in scrutinising common frameworks and how should that involvement take place?

Mark Dayan: I am not sure that I have any particular view on the process, but what you are driving at is absolutely right. In many of the relevant cases, including human tissue, which I mentioned earlier, the areas are quite technical and it is important to get them right in the interests of the co-operation of vital services across at least the UK and, I hope, the EU to some extent. There will need to be a very careful process for drawing those up.

The Convener: In relation to the discussions on potential common frameworks, it almost sounds as though you are describing a position in which the common framework in the UK is pretty light touch, other than on areas such as professional qualifications, and the common framework in the EU is pretty light touch, too. Does that mean that we anticipate relatively few issues in taking forward the position post-Brexit?

Mark Dayan: The situation varies greatly. In the core business of health services, there has never been that much EU regulation and control. However, in some areas around the sides, such as the hours that people can work, which is very relevant in governing how the medical profession works, and the conducting of clinical trials, which is how we get new medicines and which goes on in a lot of NHS hospitals in Scotland and around the UK, EU law has been very powerful. The return of those powers to Westminster or to the Scottish Parliament would open up significant freedom of movement to decide on those areas, although for many of them—clinical trials are a good example—the ideal situation is probably to continue to work with EU standards once we have left. In the interest of things running smoothly across the continent as a whole, it would make a lot of sense to continue to co-operate with the rest of the continent.

The Convener: Presumably, clinical trials have more value the more standardised they are, so people know what standards apply wherever the trial is done. Therefore, you attract trials on the basis of your ability to innovate, rather than by having a different set of standards. Syed Ahmed might have a view on that, too.

Mark Dayan: There is an element of that. There is also the fact that, particularly for some rare diseases, it is not possible to get enough people in the whole of the UK for a working clinical trial, so they have to be run multinationally. At the moment, the European Union is introducing a system that is streamlined in legal terms, as a result of which only a single form will need to be filled out in order to do a clinical trial. That should make it much easier for co-operation in Europe and it raises the possibility that, in some cases, UK scientists or doctors might not be included simply because it would be much more complex to include them.

Dr Ahmed: It is very similar in Health Protection Scotland. A number of our colleagues take part in Europe-wide clinical trials because, from a statistical point of view, they need large numbers of people to get the confidence interval and so on.

The other issue is the European Medicines Agency. The EMA licenses vaccines and medicines and, once they are licensed, that applies in all EU countries. For us to replicate that in all parts of the UK might delay the introduction of vital medicines. My understanding of Theresa May's speech on Friday is that the UK Government is looking at some kind of associate membership of the EMA so that, when it licenses something, we will automatically accept it because we will follow the same standards. It depends on the measures that she puts in place to mitigate some of the issues.

Brian Whittle: We are talking about clinical trials on rare diseases. It is my understanding that there is already a mechanism in place to recruit for trials globally, even outwith the EU. Is that the case, or are there major barriers to recruiting from outside the EU?

Mark Dayan: I am not an expert on that, but I believe that the answer to both the aspects of your question is yes. I am familiar with global mechanisms for at least some disease areas, but there are also more barriers to doing such trials outside the EU than there are to doing them within it. It is still easiest to do them within the EU. There is potential for that to be enhanced as we get the new clinical trials regulation, which streamlines things within the EU.

Dr Ahmed: Lots of international trials go on in clinical medicine. Often, the collaborative countries are the United States, Australia and New Zealand. Each home country will have a base and they will collaborate by following a common protocol. Each country needs to abide by its own regulations for clinical trials, and there are also international standards. There will collaborations in academic centres in various countries all over the world, and, as I have said, the collaborators will be based in those countries as well as in the UK.

The Convener: Thank you very much. We will pick up on that area in next week's meeting.

Finally, I ask our witnesses for any comments that they might have on the impact of leaving the EU on health inequalities, which is an area that is of particular interest to the committee. It is a very broad question, I know, but I simply ask whether there will be impacts. For example, they might include the impact on public funding that was mentioned at the beginning of the meeting or the impact on the relationship between public policy and commercial interest that has been part of our discussion.

John Watson: The connection that I would make reiterates and expands upon a previous point, in that, for us, the flexibility of Government intervention in the market is very important. We have come quite a long way, as far as tobacco regulation is concerned, but we still have an awful lot to do. We face an issue that is far and away the largest preventable cause of illness and death in Scotland, which is increasingly concentrated among disadvantaged communities. For the future, we need to look at interventions that will narrow that inequalities gap.

For example, we are conscious that the nearly 10,000 places that sell tobacco are concentrated in such communities, and that that concentration is associated with higher smoking rates. From a public health perspective, we would like to have intervention that sees fewer retailers selling

tobacco, particularly in disadvantaged areas. However, that would obviously come up against the legitimate concern of retailers in such areas that their businesses will be harmed. An innovative approach might include some kind of licensing that raises funds from across the tobacco supply chain and channels that money towards small retailers in disadvantaged communities, to help them to diversify into other products that are less harmful to their communities and have better long-term business prospects. We cannot have a licensing scheme that raises funds in that way at the moment, because of EU rules. If we are trying to be clever and have something innovative that people have not done before to address the complex situation that we now face, we will have more opportunity to do so if we have fewer restrictions on the Government's ability to intervene in the market.

Mark Dayan: I do not have a direct answer to that question because, in many senses, the duties and powers to address health inequalities already rest at Scottish and UK Government levels, and they always have done. However, I will say that, in some respects, the impact on NHS finances is a health inequalities issue in that a universal healthcare system is how the majority of people—and certainly the most deprived people—have their vital needs met.

Unfortunately, there is a laundry list of ways in which Brexit risks extra pressure on the health service, such as a reduction in the amount of tax revenue that there would be to put into it and trade disruption potentially raising prices, which would take money away from investment in the service and impact on the ability to pay for supplies. There is also the possibility that Brexit would disrupt the medicines market so that we will no longer be able to buy from cheaper countries where that would make sense. It is an indirect relationship but, depending on how Brexit is handled, the additional pressure that it could put on the health service generally across the UK relates to health inequalities in some ways.

Dr Ahmed: I will echo that. Most of the health protection services that we provide are intended to reduce inequalities in health because, unfortunately, those who come from the most deprived parts of the community are more likely to suffer from health protection diseases such as tuberculosis and viruses such as hepatitis B or C. As long as there is no overall impact on the financing of the health protection service in the UK and in Scotland, I do not see an implication.

The Convener: I thank all our witnesses for a very informative session. We will now take a break for five minutes, and we will resume with our new panel of witnesses at 5 past 11. Thank you very much, gentlemen.

11:00

Meeting suspended.

11:05

On resuming—

The Convener: I remind colleagues to ensure that their mobile phones are turned off or switched to silent. I welcome our next panel of witnesses, who are here to comment on the impact of leaving the European Union on the health and care professions. Paul Buckley is the director of strategy and policy at the General Medical Council, Dr Peter Bennie is the chair of the British Medical Association Scotland, Dr Donald Macaskill is the chief executive officer of Scottish Care, and Joanna Macdonald is the director of adult social care at NHS Highland. Good morning to you all. We have a range of questions on the impact of Brexit. Ivan McKee will start.

Ivan McKee: Good morning. I want your thoughts on the potential impact of Brexit on the workforce. A significant number of EU nationals work here across a range of occupations, some of which are very skilled. How will the workforce scenario unfold? How much potential damage could be done to the NHS, which is already struggling to find enough trained and skilled people to staff the service?

Dr Donald Macaskill (Scottish Care): Scottish Care has submitted to the committee our data from three pieces of research that were carried out last year. In general terms, the research highlights that between 6 per cent and 8 per cent of the total social care workforce—who predominantly work, in my context, with older people in communities and care homes—are European Economic Area nationals. It is significant that the figure goes up to about 8 per cent for nurses in the care context, who comprise 10 per cent of all nurses in Scotland. We have therefore been profoundly concerned for some time about the potential impact of Brexit.

I use the word "potential" because, as someone recently said to me, Brexit is a little bit like having fog around you. In fog, familiar landscapes and points of reference disappear. On my journey today from Glasgow through to Edinburgh in dense fog, there was a degree of certainty about what would be there once it disappeared; however, we do not have that degree of certainly about what will appear at the end of the Brexit negotiations, and that profound uncertainty is having a direct impact on the women and the men who are caring for individuals up and down the country.

Last week, we had an astonishing positive and dedicated reaction from our staff up and down Scotland, who literally walked the extra mile to

care for some of our most vulnerable citizens. It is those individuals whose livelihoods and futures are at risk. That fog of uncertainty is profoundly concerning to our members and to the women and the men who work in social care.

Joanna Macdonald (NHS Highland): The Highlands has remote and rural areas, so we are often first to experience recruitment challenges to key posts. We are experiencing those challenges now: at the moment, we are dependent on locum consultants in some of our most critical services.

Uncertainty is the key element in Brexit. NHS Highland has been successfully promoting opportunities in our health and social care workforce to the migrant community, and encouraging those people to be a valued part of that workforce. We have been welcoming them as a fundamental and reliable part of our social care workforce in our care homes and care at home services.

With the uncertainty about the future, we are starting to experience a reduction in the migrant workforce. The situation is more profound in the NHS Highland area because of its demographics; currently, one in five people is over the age of 65, but by 2035, that will go up to one in three, and things will be even worse in our remote and rural areas. There will be an increase in the number of older people living by themselves who have complex care and support needs, and there is uncertainty about how we will support them.

We have really welcomed the migrant community; they are part of who we are and how we deliver our services in NHS Highland, and we are concerned about what might—or might not—happen.

Dr Peter Bennie (British Medical Association): First, I want to back up what the two previous witnesses have said—in particular, with regard to the care sector. The rest of the health service is entirely dependent on the care sector running well, and I have major concerns about Brexit's effect on it. One issue that has not yet been mentioned is the generally lower wages in the care sector, and the potential knock-on effect of Brexit, certainly on current migration rules. What we are facing is totally uncertain.

On the medical perspective, the committee has our written evidence and the facts and figures from our survey. When I was coming to the committee I was thinking about the matter: what I want to put across to the committee is the human and emotional side of it. The European doctors who work with us are our friends and colleagues, and the Brexit process has been immensely disruptive and disturbing to them. We do not think that a substantial number have left the country yet, but we know from our survey that at least a third of them are considering it. Quite frankly, why would they not? They give their all to keep our health service running. We all know how stretched the health service already is, but with the thanks that they have had from the UK Government—and, I suppose, from the people of the country who voted to leave in the referendum—their feeling is that their efforts are not appreciated at all.

On potential problems, specifically with regard to the situation with doctors there is currently mutual recognition of professional qualifications within the EU. As a result, the process by which a doctor from any of the EU or EEA nations can apply for and take up a post in the UK is entirely straightforward. We rely very much on them, but we do not know what the situation will look like after Brexit. The current noises from the UK Government are reasonably positive about maintaining freedom of movement for doctors, but we do not yet know for certain. If that goes, it will have a major effect on our ability to fill recruitment gaps. Again, as I am sure you all know, we simply cannot fill those gaps with home-grown doctors; we just do not have enough of them at present, and it takes upwards of 15 years to train a doctor to be able to take on those responsibilities fully. We cannot just snap our fingers and sort this out locally.

Paul Buckley (General Medical Council): I echo the points about uncertainty that colleagues have raised. We have been told that UK exit day is 29 March 2019—a year and three weeks from now—but we do not know the basis on which EEA doctors who wish to come to the UK after 29 March will be able to access the medical register. As Peter Bennie has said, the Government's policy, which the Prime Minister reaffirmed in her Mansion house speech on Friday, is that mutual recognition of qualifications should continue, but until that is reflected in a legally binding withdrawal agreement, what the future holds will remain uncertain, so we are doing some serious thinking about contingency planning with regard to our processes.

The contribution of EEA doctors to the Scottish medical workforce is undoubtedly immense. They comprise 6 per cent of that workforce, but their contribution must not be understood purely on the basis of the raw numbers. As the Scottish Government's submission to the Migration Advisory Committee pointed out, this is also about the specialties in which the doctors work. Some of the specialties—for example paediatrics, oncology and radiology—are on the Scottish shortage occupation list.

It is also about geography: the territorial health boards in remote and rural areas depend heavily on the contribution of EEA doctors. There is an issue in relation to the stock of doctors currently

working in Scotland and their future plans, which Peter Bennie referred to, but there is also an issue about future flow into the UK. All that is uncertain. We feel that we can deal with most things, but uncertainty is the most difficult thing to deal with.

11:15

Ivan McKee: Your comments are very worrying, but not unexpected. Dr Bennie expressed very well the human aspect.

The Scottish Government would be keen to have control over some or all of migration policy for Scotland, just as several other subnational jurisdictions have within their countries. Would that be helpful in the scenario that you have described? Would you support that?

Dr Bennie: The BMA does not have a policy on that, so I will not give a black-and-white answer. However, we want post-Brexit migration policy that is able to deal with the problems at hand, that is practical and which has straightforward ways for doctors from outside the UK to come and work in the UK, including in Scotland.

Paul Buckley mentioned the shortage occupation list. I presume that the committee knows that there is a UK shortage occupation list, with a supplementary Scottish list above and beyond it. We already have a degree of separation and the ability to pick and choose which areas we in Scotland see as having shortages. We are very comfortable with that mechanism and would certainly want to continue with a process that allows Scotland to make sensible decisions on its medical workforce.

Dr Macaskill: From the social care perspective, Scottish Care has submitted evidence to the Migration Advisory Committee and the Westminster review of potential migration policy and practice. We have experience of the current shortage occupation list. We have been calling for whatever model is adopted, by whoever, to be as flexible and responsive as possible. Our experience of immigration from outwith the EU is that the difficulties, particularly for small providers and providers in rural and remote areas, make it completely impractical as a resource. Our concern is that the process post-Brexit—whoever has responsibility for it—needs to enable fairly quick inward migration to key areas, in terms not just of geography but of roles. We are concerned because that is not currently being discussed.

Dr Bennie: There also needs to be a default option to ensure that the people who are here already do not fall foul of relatively detailed legislation. I will give an example.

A colleague of mine came to the NHS from India and took a decision, with the health board, to start work at specialty doctor level, even though he was technically entitled to work at consultant level. He did that on a trial basis, and then, when he and the health board were clear that he was capable of working at consultant level, he went through an appointment panel and was appointed as a consultant. However, nobody spotted that the Home Office had to be told about that, so he was told some years later and with absolutely no notice that he was working outside legislative requirements and faced deportation there and then. He was not deported, but he spent three weeks uncertain about whether he and his family would be allowed to stay in the country.

We must have flexibility and common sense in migration rules, and we should view as a starting point what the country needs. Does the country need doctors and health service staff to be here looking after our population, or does it need to find ways to get rid of these people? I believe that it needs the former.

David Stewart: I want to ask a specific question about evidence that we have had from the Royal College of Physicians of Edinburgh, although Joanna Macdonald has partly answered it already. There is disproportionate reliance on EU-national doctors, especially in hard-to-recruit specialties such as paediatrics. Does Joanna Macdonald have any additional points on how NHS Highland is planning its workforce management post-Brexit?

Joanna Macdonald: We have been working collaboratively with the University of the Highlands and Islands on promoting NHS Highland as an organisation that will focus on research, development and innovation, in order to attract people from the EU and elsewhere internationally to work in NHS Highland. We have had significant success in that, but we also have concerns about it because the UHI is the university in Scotland that will be most affected by the withdrawal of European Union support. We have benefited greatly from the transition region status of the Highlands and Islands and there are a number of projects and areas of work across the UK, as well as across Europe, in respect of which we are unclear and uncertain about the future of funding. However, the research and development has been a real attraction to what is obviously a minority of doctors and consultants, but it is an area in which we are progressing.

David Stewart: I add that the role of horizon 2020 and structural funds has been vital to the Highlands and Islands. I highlight that there has been a lot of good collaboration between UHI and private institutions on diabetes research, for example, as Joanna Macdonald will know.

I will move on to a point that Dr Bennie made extremely well about recruitment of non-EEA citizens. It is, of course, much more difficult to

recruit from outwith the EU because of Home Office visa restrictions, about which we have just heard. Do any of the panellists have any general views about recruitment into specialties for which candidates are scarce—for example, trainee psychiatrists, of whom I think 41 per cent come from the EEA? Is it very difficult to recruit from outwith the EU?

The Convener: Dr Bennie gave us a very good example earlier. Does anyone else want to comment?

Joanna Macdonald: We are currently looking regionally, because the issues of recruitment and retention in remote and rural areas affect NHS Highland more significantly than they do other areas, I argue—although colleagues might not agree. We have the most remote hospitals, in which recruitment is a huge issue.

On recruiting from the EEA, we are currently looking at how we promote ourselves internationally. The flipside of that is an ethical dilemma, which I was discussing with colleagues earlier: we will potentially be recruiting expert consultants from countries where they would benefit from remaining, so we obviously have to consider doing whatever we can.

The issue is also linked to our current models of health and social care service provision. We recognised prior to Brexit that we need to change and adapt those to reflect the challenges that we face in recruitment across health and social care. There is significant work being done on that. However, as I said, it is an ethical issue as much as it is about needing to fill our vacancies.

Dr Bennie: I will add briefly to that. The committee asked us to come up in written evidence with potential benefits from Brexit. You may have spotted that we struggled a bit with that. However, there would be potential benefit if, as a consequence of Brexit, we were to move to a system that is more flexible at recognising service needs across the board, in respect of people coming from any country outside the UK.

My fear about that is that the whole question of freedom of movement and immigration was very closely entwined in the Brexit referendum, so it looks to me as though it would be quite a challenge to tease the two things apart. Perhaps the way to achieve that is to focus on the crucial importance of immigration to running national services—health services and others.

The Convener: The point that you are making is that there is a big difference between equalising up and equalising down.

Paul Buckley: My point is not on immigration, which is not directly within the GMC's sphere of responsibility, but on the fact that the alternative to the current mutual recognition system is very burdensome and time consuming for specialists. A person from outwith the EU who wants a consultant post must go through a very laborious process that can take many months and which involves huge amounts of documentation. The same applies for the process of getting on to the general practitioner register. Some work is being done in parts of the UK—including Scotland, under Dr Emma Watson—on simplifying the process.

However, without changing the legislation, there are limits to what we can do. We feel that, as part of trying to future proof the system against the risks of Brexit, we should make the process for getting doctors from other parts of the world on to the specialist and GP registers in particular much less burdensome than it currently is. We think that that needs to happen regardless of the Brexit scenario that will ensue.

Miles Briggs (Lothian) (Con): Good morning, panel. I am interested in Mr Buckley's comments on future proofing. The committee has been involved in and concerned about that, because it is clear that, over the past 10 years, there has been a real issue with NHS recruitment, particularly in the social care workforce, which is why we carried out a short inquiry on that.

I want to talk about the unintended consequences of policies, in Scotland and in the European Union. I point to two specific areas in which this Parliament can have a role: the cap on the number of Scottish medical students and future recruitment in social care. Dr Macaskill, when you gave evidence to the committee previously, I think that you mentioned that childcare places had become the real focus in the college sector. What does the panel feel can be done to stabilise all the challenges that have been outlined?

Dr Macaskill: Clearly, there are potential unintended consequences. The second part of the workforce plan, which relates to social care, highlights what I have stated previously in evidence: the recruitment of 20,000 individuals into early years will potentially have a negative impact. I was not saying then, nor do I say now, that we should not be recruiting people into early years. The role of early years is hugely significant. At a previous meeting, in response to a question from Mr McKee, I suggested that, alongside that recruitment in early years, we need significant investment in social care to address the fact that nine out of 10 providers struggle to recruit. The survey that we are due to publish next week highlights that we lose a third of those whom we manage to recruit within the first six months. We are looking collectively at some of the reasons behind that fact, but it is not necessarily the case

that a single policy needs to be altered; it is about the wider landscape.

Dr Bennie referred to the elephant in the room: the fact that social care workers are, relatively speaking, underpaid for the huge skilled role that they deliver in Scottish society. That point goes beyond the committee's remit, but we cannot think about the impact of Brexit without thinking about the fact that we place so little value on our social care staff in care homes and in care home services.

Dr Bennie: Miles Briggs mentioned medical student numbers. The committee will be aware of the new graduate entry medical student programme, which will come on stream later this year and which is designed to retain more Scottish graduates in Scotland. In particular, it will try to encourage greater recruitment into general practice and rural practice. It remains to be seen how successful that programme will be and, of course, all the delays that are inherent when starting from scratch and trying to develop new doctors are built into the programme. However, moves are afoot to try to increase the number of medical students in Scotland and therefore, by definition, increase the numbers of those who stay in Scotland to work.

Another issue, which is almost certainly not directly the issue for this committee, is that joined-up policy making has to include a recognition that we have serious problems with recruitment and with retention. Retention seems not to feature anything like as much as recruitment in our considerations, yet recruitment—particularly to medical school—does not solve a problem until 10 or 15 years down the road. Given that, when people get to 55 or 60 they stop working, retention—or the lack of it—is a far more immediate issue, but there tends to be less focus on it.

11:30

Miles Briggs: With respect to what you have said about low-paid work, what impact has the pound's devaluation had on EU nationals wanting to come to work in Scotland, especially given the EU labour market recovery in recent years? All of us value what EU citizens do to help run our health service, but are we becoming less attractive purely because of economics as well? Have you undertaken any work on that?

Dr Macaskill: We have undertaken work on that, to a degree. Without doubt, anecdotally, a not insignificant number of individuals have chosen to go back to Europe as a result of the devaluation of the pound. That reason is often cited. It is not about a lack of desire to remain in Scotland to bring up children and have this place as a home. That sense of being unwelcome that others have referred to, and the sense of uncertainty, combined with the economic reality that the uncertainty around Brexit has resulted in the devaluation of the pound, makes people's homes—that is, their previous homes—more attractive. It is a circular argument that is undoubtedly having an impact.

Joanna Macdonald: We have undertaken significant work in NHS Highland. Health and social care have been integrated for six years, so we have a better flow between them. Working with our care homes and our care-at-home sector more collaboratively, we have seen improvements. One hundred per cent of our NHS care homes received grade 4 or above from the Care Inspectorate, as did 87 per cent of those in the independent sector. We have looked at the value of the care homes. However, because of uncertainty and concern about Brexit, we have not been able to address the high number of staff vacancies. Even some of our own care homes are now dependent on agency staff and agency nurses from the independent sector.

An unanticipated consequence of the living wage, which was welcomed by the sector, is that, in some of our independent care homes, staff at more senior levels are being paid at similar levels to the living wage. That is a concern. When we made projections on that issue and looked at how to address it, even prior to Brexit, there were questions about how we would sustain the current care home model.

We also recognise that, in NHS Highland and across Scotland, care homes in rural areas will be attractive for adult social care staff to work in. With integration, we are now pooling our auxiliary nursing posts and social care posts and making them available to the same population of staff.

One opportunity that we have is to look at how we encourage the younger workforce to come into the health and social care sector. Our workforce in NHS Highland is ageing, and we are not unusual in that—over 50s are apparently getting older, and I am nearly there. There is a question about why we are not recruiting our own younger workforce into health and social care. We are starting to look at that area.

Alex Cole-Hamilton: Good morning, panel. I am grateful for the written submissions that you have provided, and in particular for the breakdowns of workforce in terms of EEA citizenship. I was struck by the exposure that we seem to have, given the number of surgeons who are from other European countries. All my colleagues round the table are familiar with cases that come to us of extended, prolonged and protracted waiting times for surgery. There are two reasons for that. One is, obviously, capacity in the

workforce, and that is an immediate risk. The second touches on Donald Macaskill's point about the social care workforce. Without adequate social care provision in our communities, people stay in in-patient beds for longer and elective surgical appointments are cancelled as a result of that bedblocking. Are we facing a perfect storm in that regard? How should workforce planning ensure that we have sufficient home-grown surgeons should there be a sudden dramatic reduction in surgeons from European countries?

Dr Bennie: Substantial changes and improvements to surgical training schemes are happening in a pilot that will start running this summer. It is UK wide, but the majority of the training posts are in Scotland, because of a decision to change all the training posts to the pilot. It may sound odd, but it will concentrate on all the training actually being training. If you have spoken to junior doctors, you will know that the model for years has tended to be that they provide a service and happen to pick up some training as they go along. The pilot prioritises training time away from the workforce to work on simulation and rotas are changed so that the people being trained have enough space and time to think and train properly. That is the theory, although it remains to be seen how it will work in practice. If it works, the Scottish surgical colleges and surgeons will in effect have taken a decision to get ahead of the game and change to the new form of training before it goes right across the UK.

Brian Whittle: I pick up on a point made by Miles Briggs. A couple of people in my surgeries have suggested that they had the qualifications to do medicine at university in Scotland but there were no places for them. I accept Mr Bennie's point about retention but, on recruitment, as a consequence of Brexit, will more places be available for people who are qualified to do medicine but for whom currently there may be no places?

Dr Bennie: We cannot know for sure, but it is reasonable to assume that fewer people will wish to come from the rest of Europe to Scotland and the UK to study medicine after Brexit day. Medical schools have always been hugely oversubscribed, with many more people wanting to study medicine than places. We have tended to view that as not a bad thing, because it has meant that competition is strong to get into the training in the first place.

A key issue is to ensure that we select as best we can. Selection for medical school used to be based pretty much on whether applicants had the main qualifications, which in Scottish terms means the highers. We have moved away from that to try to identify people who are most likely to have the attributes to be good doctors. They have to have the qualifications, but now they need the attributes as well.

Brian Whittle: If medical schools are hugely oversubscribed and we are short of doctors, is there not a tension there?

Dr Bennie: Absolutely. Bear in mind that the training of medical students is primarily done not by universities or full-time university employees but by NHS GPs and consultants, usually with limited recognition of the time that is needed to do it. A very substantial increase in the number of medical students would be unsustainable at present, because we do not have enough doctors to train them, enough patients for them to see or enough space for them to train in. That is also a tension in the system.

The Convener: Alison Johnstone has questions on recognition of qualifications and regulation of professions.

Alison Johnstone: My first question has, I think, been answered. Dr Bennie seems to be of the opinion that reciprocal arrangements such as the MRPQ should be maintained.

Dr Bennie: That is right.

Alison Johnstone: Is there any opportunity here to review and agree the minimum training requirements?

The Convener: Does Paul Buckley wish to answer that?

Dr Bennie: I was going to say that that is probably a question for Paul to start with, given that that is his area of expertise at the GMC.

Paul Buckley: I am happy to start off.

As we have said in our submission, we see significant benefits in the current mutual recognition regime. However, there are some downsides, too, and it is possible that, in looking to a future beyond 29 March 2019, we might have opportunities to achieve a slightly better balance between flexibility and speed with regard to getting people on to the front line and assuring patients of the capabilities of doctors and other healthcare professionals.

I can give a couple of examples. If I was training to be an anaesthetist in Latvia, I could complete that training in three years, but that takes seven or eight years in the UK. If I was training to be a family doctor in parts of southern Europe—say, Italy—I would not be doing much, if anything, by way of paediatrics or antenatal or postnatal care, while those are staple elements in primary care in the UK. Those two examples illustrate our concern about what is really quite a blunt instrument in the recognition of professional qualifications directive, and we feel that there is an opportunity to revisit some of that.

Those are examples of areas where the current regime is, in our view, too permissive, but there are also examples of areas where we feel that it is too restrictive. For example, if I am training in postgraduate paediatrics and I want to change to be a general practitioner, I get no discount or allowance under the directive for the paediatrics training that I have done to date and which I can carry across, and I get only a discount of up to 50 per cent if I complete that training. Most people who want to change horses do so midstream instead of when they get to the other side, and we think that that is another area that needs to be revisited. The system is by no means perfect.

Dr Bennie: Just to add to those points in, I suppose, reverse order, it has certainly been the BMA's view for a long time that moving between specialties during training should be more straightforward. We are all aware of people who have done seven or eight years' training in a specialty, have decided that they would prefer to do something else and have had to start from scratch and do another six or seven years in a different specialty. There is clearly some common ground in learning to be a doctor. Of course, that issue is not purely bound up with Brexit, and we are trying to make changes through the shape of the training process.

On the first point, it is important to remember that having the legal right to be on the GMC register as a specialist in, say, surgery is not the same as walking into an appointments panel and being appointed as a consultant surgeon. There is a quality process right at the start. If you apply to be a consultant, you come before a panel whose job is to ensure that you are able to do the job in front of you, not just that you are able to be registered as a specialist.

Alison Johnstone: On a wider point, this morning we received an email saying that 10 health boards in Scotland have not yet met their child and adolescent mental health services waiting times targets. As David Stewart has pointed out, 41 per cent of psychiatry trainees come from outwith the UK. Even if we improve things and are able to have a more sensible qualifications framework, we are not going to get any further if it proves difficult to get people from outwith the UK to come and work here.

From what I have heard this morning, I get the feeling that we are not paying due attention to the need for a more welcoming immigration system that will allow us to keep the people in Scotland whom we need to have in Scotland. Even if we were to promote social care as an attractive career for UK nationals, as it should be promoted, what I have heard this morning leaves me concerned that we simply will not have enough people in post regardless of how we refine training requirements and so on. Does the panel share that view?

11:45

Dr Macaskill: Dr Bennie has highlighted that retention is critically important. As an organisation, we have produced report after report to highlight the recruitment challenge. We have astonishingly skilled women and men—predominantly women, who make up 86 per cent of them—working in social care provision in Scotland, and we need to do everything we can to retain them.

In October, in social care, we saw the introduction of qualification requirements through registration with the Scottish Social Services Council. We are concerned about getting the balance right between valuing a role and the skill that is required to undertake that role by professionalising it and the recognition that the majority of our workers are individuals who are, as Joanna Macdonald hinted, over 50 and mature in life. For them, concepts such as undertaking an apprenticeship or not having their skills valued because they have to go back into training presents a challenge. We will have to keep an eye on that, particularly in the care home sector, because 6,000 people are currently registered and need to finish their qualifications by January 2019. With the SSSC, we will support those individuals to finish.

We must get the balance right between retaining a skilled workforce, valuing and rewarding that workforce, and making social care attractive. Although Joanna Macdonald is right, we must continue to try to attract more young people. The majority of individuals who will enter the social care workforce in the next 18 months will be women over the age of 45. They will have multiple skills and life skills but, for various reasons, they will have low self-esteem and, for them, formal training and education will be quite frightening. There is a lot of work to do to retain the workforce as well as to build it into an attractive profession and a career that offers real potential.

Paul Buckley: I agree. The GMC is trying to contribute where we can. For example, our welcome to UK practice programme helps healthcare professionals and doctors who come from other parts of the world to understand the context of practising in the UK. It is a small programme, but we feel that it is a valuable contribution to setting them up to succeed.

Peter Bennie's point about needing to do more to keep good doctors in the system is absolutely right. That is why, within our education and training responsibilities, we take issues around culture and bullying seriously. Those kinds of problems drive people out of the profession or

elsewhere. It is, therefore, really important that issues around retention are addressed as well as the need to get people on to the register in the first place.

Joanna Macdonald: The debate is about Brexit, but the Highlands and Islands have benefited from being recognised as a transition region. That status has enabled us to access and benefit from European funding.

Recruitment and retention are a huge challenge for us in the Highlands, and I am concerned about the University of the Highlands and Islands. There is not just a risk of migration; the draw of the central belt for our young people in the Highlands and the north is huge. Our young people come down to universities in Glasgow and Edinburgh, and often they do not return. I am making a plea to look at how we support the whole of Scotland in its diversity and richness, with all the challenges that we have been describing today.

Dr Bennie: I agree with the basic premise. We must be careful, because everything is coming together at once and we potentially face a vicious circle. We were facing a recruitment crisis in the health service before the Brexit vote, and it is hard to imagine that the outcome of Brexit will mean anything other than a considerable worsening of the recruitment problems.

There will certainly be a temptation in medicine, when we are running short of doctors in any individual unit, for pressure to build to weaken the current legislative protections, which, ironically, started in Europe more than a quarter of a century ago with the European working time directive, which is enshrined in UK law as the Working Time Regulations 1998. One of the first things that happens when doctors are missing from a rota is that the service tries to get the others to work above and beyond their agreed hours; without those legislative protections, there would be even more risk of that happening.

At present, we are receiving reassurances, from the Prime Minister down, that there is no intention to make any changes to the working time regulations. However, we are always conscious that, every few years, the regulations come up as a potential issue. Furthermore, as soon as people started to talk about Brexit, those who oppose the regulations said that this was the opportunity for change. We need to be vigilant.

The Convener: We will discuss that issue in more detail in a moment. Before we do so, I want to ask Paul Buckley about the advantages and disadvantages of the current mutual recognition arrangements that apply. What changes does the GMC consider are needed to its powers under the Medical Act 1983? I understand that that is the key legislation in relation to your future regulatory activity.

Paul Buckley: It would be possible to simply roll forward the current regime, although there would probably need to be minor changes to the Medical Act 1983, to remove any references to directives or European institutions to which the UK would no longer be subject. In drafting terms, that would be relatively straightforward.

I think that the principle of mutual recognition could be rolled over without any difficulty. However, we need to consider whether there might be a slightly better, more proportionate way of doing that. We want that opportunity at least to be considered before it is dismissed, but we recognise the workforce pressures that might lead you to say that you do not want any changes.

The Convener: I presume that, because of differences in training regimes, it would be difficult to negotiate changes in mutual recognition arrangements with the European Union line by line, given the timing constraints in delivering a final outcome to the Brexit process.

Paul Buckley: There are a couple of issues in that, one of which is transition. We are all assuming that there will be a transition arrangement, because that is in the withdrawal agreement that has been reached. However, the agreement is not enshrined in law. At the moment, it is perhaps more of an aspiration and not a certainty, which is a problem.

The chair of the Health and Social Care Committee at Westminster wrote to the Secretary of State for Health and Social Care on 15 February, asking for certainty beyond UK exit day and a declaration between the UK Government and the European Union about what the position will be beyond March next year. In the event that it is not possible to make a joint declaration, the chair asked that the UK Government make a unilateral statement about that.

Emma Harper: Dr Bennie mentioned the working time directive, which is an issue that I am interested in pursuing in a wee bit more detail. The EU directive was introduced 25 years ago, in 1993, and it was successfully implemented in the NHS from the beginning. It limits staff working time to 48 hours a week and sets the minimum daily and weekly rest breaks, and the rules include time that is spent on call.

Dr Bennie intimated that people have jumped on Brexit as a reason to change the rules. I am curious about the long hours. Do they present an optimal learning opportunity or a safety issue?

I have a couple of examples. The first is people assessing and diagnosing patients when they are tired. The second is that, when people are giving

intravenous medications, complex calculations are required, and, when they are working in surgery, swab, needle and instrument counts require to be accurate. I am a former liver transplant nurse who has witnessed doctors fall asleep while holding abdominal retractors in the middle of a long on-call shift. I am curious about the possible advantages and disadvantages if the working time directive is altered.

Dr Bennie: The first thing to say is that—at present, at least—we are getting clear reassurances that there is no intention to alter the working time regulations, but we will continue to stand up strongly for them. I am of the generation that remembers the time before there were restrictions on junior doctors' hours. I have done those 100-hour weeks and, indeed, I was holding retractors during some of that time. I will be honest with you—I sometimes nearly fell asleep holding a retractor after I had been on for only two hours, as it is immensely boring. I am now a psychiatrist.

Joking aside, we have always viewed junior doctors' hours as a health and safety issue, primarily for patients but also for the doctors, because a well-known side effect that you did not mention is the potential damage to the individuals themselves, up to and including fatal car crashes when the individuals drive home after a shift, having had no sleep. We are wedded to the principle of maintaining the regulation of doctors' hours.

The arguments, such as they are, that have come up over the past quarter century—and that came up even before the working time regulations came in—have tended to be about the idea that it is necessary for people to work a certain number of hours and shifts in order to get the necessary experience and training. That idea has been clearly debunked, including—very well—by what is known as the second Temple report, which was written by the surgeon Professor John Temple. The importance of training is in the quality of training that people receive, not in the number of hours in which they do it. That is very much ingrained within the pilot for changes to surgical training that I mentioned earlier.

Paul Buckley: A few years ago, we commissioned some research from the University of Durham on the impacts of the working time regulations. I will mention a couple of things that came out of that research. First, the issue is not simply about the quantum of hours worked; it is also about the intensity of what happens during those hours, and we need to look at both of those things.

Secondly, part of the difficulty—in so far as there has been some difficulty—has been to do with the interpretation by the European Court of Justice in two particular cases regarding medical training. The SiMAP and Jaeger rulings basically said that rest periods must be counted as work, which has caused some difficulty in the designing of rotas. At times, we get into a paradoxical position in which something that is intended to help with the health and safety of the employee—the doctor—can have unintended adverse consequences.

I do not think that anybody would argue for going back to the long hours of the past, but it may be helpful to look at one or two issues around interpretation as we move forward.

The Convener: Thank you. We will move on to the impact on health and care of trade agreements and the issue of common frameworks.

Ash Denham: Good morning, panel. It is still morning—just. I asked the previous panel a similar question. What potential risks are there to the NHS, health and social care in Scotland from the future trade deals that the UK Government may negotiate, perhaps on Scotland's behalf, even without very much input from the devolved nations? The BMA's written submission states:

> "one key issue would focus around competition and whether any potential deals could lead to enforced competition in public services".

What risks are there? Should the NHS be exempt from future trade deals?

Dr Bennie: I do not think that I have anything to say that is different from what we have given you in our written evidence. In the interest of time, I will let the others speak.

12:00

Joanna Macdonald: It was interesting to hear the previous witnesses talk about the difference in Scotland and the pride that we have in our NHS—and the fact that it is our NHS. My view on that is that we should be proud of what we have got and where we are going with the integration of health and social care. We should look at the potential negative impacts as well as the positive impacts in thinking about trade deals differently. However, as I have said, I do not have a view on that because I do not have sufficient knowledge at the moment.

Dr Macaskill: From the social care perspective, we have a tremendous piece of legislation around procurement in Scotland, with specific guidance for social care procurement, which is based on principles of personalisation, on the engagement of those who are impacted by the service and on human rights. It is not beyond the bounds of imagination that any of those three issues could be challenged in an overtly competitive model of procurement.

For too long, we, in social care, have experienced the misuse of competitive tendering

models in the home care and housing support sector, ostensibly because that was the best available approach to designing packages of care for people. As we are collectively agreeing that we need to move away from such commissioning and procurement models in order to build more reciprocal models, it would be deeply unfortunate if, because of behaviours elsewhere, we were unable to continue that journey towards making the art of procurement and commissioning more person centred.

Jenny Gilruth: In our inquiry, we are asking about common frameworks. I note that the submissions from the BMA and JMC did not provide an explicit answer, so I will give you an opportunity now to put your views on that subject on the record. I accept that Donald Macaskill provided an answer to that question in his written submission. The written submission from NHS Orkney says:

"The Common Frameworks arrangements could limit the extent to which the Scottish Parliament can tailor legislation to meet Scotland's specific requirements, particularly if the frameworks are developed via legislation at Westminster rather than as intergovernmental agreements."

Does the panel have a view on how stakeholders can be involved in scrutinising those common frameworks?

Dr Bennie: Curses! You spotted that we did not answer that question.

We have talked about the fog of Brexit, and this aspect seems even foggier—if you like, it is the foggy hills behind the foggy plain that we are on just now. That is why we did not answer the question. We do not have an answer for you because we do not know what we are going to be facing. To some extent, almost all the evidence that we are giving you just now is partially hypothetical but, on this issue, we struggle to know what we could say at the moment that would be meaningful.

Paul Buckley: The fog surrounds us on this issue as well. However, we are clear that, although we are a UK regulator, we want, as far as is possible, to tailor our regulatory model to meet the challenges and circumstances of the four UK countries, recognising that healthcare is a devolved matter. That is what we are trying to do, and we will continue to do that.

Dr Macaskill: We have one solid concern in the midst of the fog. In Scotland, we have developed a health and social care system that is legislatively based on sound human rights principles—we have core pieces of legislation around adult support and protection, adults with incapacity, and mental health care and treatment—that are all coherently based on the ECHR and the Human Rights Act 1998. Further, particularly in the care home sector, which is my sector, we are rolling out health and care standards that are deeply rooted in the 1998 act and human rights principles. Part of the background noise to some of the on-going framework discussions involves the context in which part of the Administration south of the border wishes to remove us from protections and the safeguards of that human rights legislation. That is causing us profound concern, because it impacts on the day-to-day delivery of care and support, all the way up to procurement and commissioning and all the way through our training and development. If greater clarity in the fog reveals that to be an increasing threat, Scottish Care will be extremely concerned about the negative impacts of that not just on social care but on the NHS itself.

Dr Bennie: As will the BMA.

Joanna Macdonald: The governance that we have in Scotland, particularly around social care service delivery, is unique in the UK. We have the Care Inspectorate, which inspects and regulates our care services, and we have a workforce that is increasingly becoming qualified and competent and which is registered with the Scottish Social Services Council. We want to build on that so that we can have confidence in the care and support that vulnerable people in Scotland are receiving. As my colleagues have said, we want to ensure that any framework builds on what we already have and the uniqueness that exists in Scotland and that it does not detract from anything that we have spent a number of years building up. In relation to Europe, the governance and the stature of adult social care is something of which we should be proud.

The Convener: We have heard some strong points from each of the witnesses about things that would make a difference. Do any other witnesses want to suggest anything that the committee could do to assist with the challenges that you are all going to face? If not, I take it that we have covered all the germane points, which is excellent and shows that we have used our time very well.

I thank all the witnesses who have attended the committee today.

12:06

Meeting continued in private until 12:26.

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