OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 20 March 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 20 March 2018

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HEALTH AND SPORT COMMITTEE
10th 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:

Shona Robison (Cabinet Secretary for Health and Sport)
Shirley Rogers (Scottish Government)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 20 March 2018

[The Convener opened the meeting at 10:00]

Subordinate Legislation

Duty of Candour Procedure (Scotland) Regulations 2018 (SSI 2018/57)

The Convener (Lewis Macdonald): Good morning and welcome to the 10th meeting in 2018 of the Health and Sport Committee. We have apologies this morning from Alison Johnstone. I ask everyone in the room to please make sure that mobiles are switched off or to silent. I also remind everyone in the room not to record or photograph proceedings, as that will be done for us by Parliament staff.

Agenda item 1 is the consideration of four Scottish statutory instruments that are subject to negative procedure, the first of which is the Duty of Candour Procedure (Scotland) Regulations 2018 (SSI 2018/57). Members will recall that the duty of candour is an issue that was raised during the committee's inquiry into national health service governance. There has been no motion to annul lodged and the Delegated Powers and Law Reform Committee has not made any comments on the regulations. As members have no comments on the regulations, do we agree to make no recommendations on them?

Members *indicated agreement.*

National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018 (SSI 2018/66)

The Convener: The second and third instruments relate to the general medical services contract. The committee previously considered and agreed a draft approach to consideration of the contract and we agreed that, following publication of the primary care improvement plans, which are expected in July, we would issue a call for written views. We have also agreed to hold an oral evidence session with key stakeholders later this year, to inform us about the implementation of the contract and delivery of primary care.

The second instrument is the National Health Service (General Medical Services Contracts (Scotland) Regulations 2018 (SSI 2018/66). There has been no motion to annul lodged. However, in this case the Delegated Powers and Law Reform Committee has made comments on the instrument under general reporting grounds and it has noted a number of drafting errors in the instrument, which the Scottish Government has undertaken to lay amending regulations in early course to correct.

Do members have any comments on the regulations? There being none, and given the commitment of the Government to correct the errors in the regulations, does the committee agree to make no recommendations on them?

Members *indicated agreement.*

National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2018 (SSI 2018/67)

The Convener: The third instrument is SSI 2018/67. There has been no motion to annul lodged. Unfortunately, there has been comment from the Delegated Powers and Law Reform Committee under general reporting grounds, noting several drafting errors in the instrument. The Scottish Government has undertaken to lay amending regulations in early course to correct the errors.

I invite any comments from members of the committee on the regulations. There being none, do we agree that we should make no recommendations on the regulations?

Members *indicated agreement.*

National Health Service (Pharmaceutical Services) (Scotland) Amendment Regulations 2018 (SSI 2018/68)

The Convener: The fourth and final of instrument is SSI 2018/68. There has been no motion to annul lodged and the Delegated Powers and Law Reform Committee has not made any comments on the regulations.

Are there any comments from members of the committee? There being none, do we agree to make no recommendations?

Members *indicated agreement.*

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

10:03

The Convener: That takes us swiftly to our second agenda item. I welcome to the committee once again the Cabinet Secretary for Health and Sport, Shona Robison, and Shirley Rogers, the director for health workforce and strategic change. This evidence session is on the impact of leaving the European Union on health and social care in Scotland. Members will have seen the letter from the cabinet secretary that was circulated with the papers. I invite the cabinet secretary to make an opening statement.

Shona Robison (Cabinet Secretary for Health and Sport): Good morning and thank you, convener. I am pleased to have the opportunity to give evidence on the implications of Brexit for health and social care in Scotland.

We are now almost exactly a year away from the day on which the United Kingdom will withdraw from the European Union. People in Scotland voted decisively to remain in the EU and I continue to believe that that is the best option. Short of EU membership, the Scottish Government believes that we should stay inside the single market and the customs union. Given the announcement yesterday, it now looks certain that progress will be made at the European Council later this week on the form and duration of a transition period, then talks should start in earnest on the future relationship between the EU and the UK. The outcome of those talks will have a major impact on economic and job prospects for current and future generations. The stakes could hardly be higher.

As I said in my letter to the committee of 24 January, the EU does not have huge competence over health and social care. Nevertheless, the implications of withdrawal are manifold. I outlined five key areas of concern, which have all been drawn to your attention in written evidence and your oral evidence sessions, which I have been following closely.

The first thing that I want to make clear is that EU citizens currently make a vital contribution across the public sector in Scotland, including in our health service, where they often fill skilled vacancies in hard-to-recruit specialisms in geographical regions, and in our social care sector, where they fill many vital roles. The Scottish Government has been clear that our fellow EU citizens who have chosen to live and work here are welcome, that this is their home and that we want them to stay. If free movement of EU nationals in the UK is curtailed as a result of the Brexit negotiations, it could have serious consequences for recruitment and retention of health and social care workers in Scotland. It could also negatively impact the free movement of medical researchers between Scotland and other EU countries and affect the ability of our academic institutions to attract medical students to come here to study and train, which would impact on the provision of healthcare.

This Government does not want any of that to happen, and we have made that clear with concrete policies such as guaranteeing that undergraduate tuition for non-UK EU students will be free for the duration of studies, even after Brexit, for those beginning their studies in the period from now until the academic year 2019-20. We have also committed to looking to pay the fees of EU citizens working in the Scottish devolved public services who wish to apply for settled status.

What we need to do now is ensure that, whatever may come from the Brexit negotiations, Scotland is able to continue to benefit from free movement from Europe and is able to manage international migration in a way that addresses our specific needs. That policy has been set out in detail in the recent Scottish Government paper "Scotland's Population Needs and Migration Policy".

A second area of concern relates to medicines and medical devices. As the committee heard last week, with 82 million batches of medicines crossing the UK-EU border per month, any decision that results in the UK leaving the EU as the regulatory regime for medicines and medical devices could have a detrimental impact across our health service. The risk is that patients might suffer as a result of slower or reduced access to new medicines and equipment. There could also be an economic impact on the pharmaceutical and medical devices industries here in Scotland. The ability to continue to operate or participate within the range of relevant EU frameworks and legislation would be in the best interests of Scotland. In our view, the best way to meet the UK Government's stated commitment to continued close working and collaboration with the EU is for the UK to remain within the European Medicines Agency and to continue to secure access to the EU clinical trials portal.

Withdrawing from the EMA is highly likely to be detrimental to patients. The risk is that pharmaceutical companies could be less attracted to the UK market than they would be to the larger combined states of the EU and the US, potentially resulting in delays to patients getting access to the medicines they need. We are also concerned that medicine manufacturers could be negatively impacted by additional costs as a result of having

to work separately with the UK. That may mean that some manufacturers choose not to do so at all.

In July last year, I wrote to the Secretary of State for Health and Social Care, Jeremy Hunt, urging him to secure the UK's continued place within the EMA. Lord O'Shaughnessy's response to my letter in August, setting out the UK Government's intention to continue co-operation with the EMA, was less than reassuring, given that there is no example of a non-European Economic Area country having associate membership of the EMA. Against that difficult background, I can confirm that my officials are in close and regular contact with both the Department of Health and Social Care and the Medicines and Healthcare products Regulatory Agency to ensure that we are as ready as possible for any of the possible scenarios that may arise in this area as a result of Brexit.

Our third concern relates to those areas where we may need UK-wide common administrative frameworks if EU law is no longer applicable. There is a clear issue of principle at stake here in what might seem like rather an esoteric argument. We have always been clear that, on leaving the EU, common UK frameworks may be desirable or necessary in some areas and that we would agree to them where it is in Scotland's interests, but we absolutely cannot accept the imposition by the Westminster Government of common UK frameworks, whether legislative or non-legislative, nor will we trade consent for consultation. If there are to be such UK frameworks, Scotland must agree to them.

In the health and social care portfolio there are a number of interests covered in the list of policy areas subject to discussions on UK common frameworks, which was published by the UK Government on 9 March. I will mention just two of them now, with the caveat that discussions on all areas are still on-going and that no final decisions have been taken.

The first is that changes to the current UK-wide system for mutual recognition of qualifications for a wide range of healthcare professionals could have profound effects on recruitment and retention on top of those that I have already mentioned. My view is that cross-border recognition of professional qualifications, education and training has to continue in order to support that workforce supply pipeline. If it does not, we will have an immediate and serious problem post-Brexit.

The second is reciprocal healthcare. We recognise that the rights of Scottish citizens to access state-provided healthcare across the EU, and vice versa for EU citizens in Scotland, should be guaranteed after Brexit. Some progress has been made on this area in negotiations with the EU, but uncertainty remains. My officials have been working closely with the Department of Health and Social Care and with other Government departments in these areas, in the context of the negotiations with the EU and the UK Government, on the possible need for common frameworks to ensure that Scotland's interests are fully protected.

My fourth concern is that the Brexit negotiations have created uncertainty in relation to research, particularly with regard to access to future EU funding and collaborative EU partnerships in areas of interest for Scotland such as dementia and alcohol. The Scottish Government is keen to see on-going access for Scottish organisations to EU-funded research programmes, which will be important to ensure that Scotland can continue to be at the forefront of on-going international research collaboration. Loss of access to EU funding such as horizon 2020 will significantly impact on research in Scotland, unless mitigated. It is likely that international companies will be more likely to invest in facilities and manufacturing in the EU, which is a significantly bigger market than the UK, rather than risk tariffs and other barriers to trade. Withdrawal from the EU brings a real possibility of creating a research funding gap. Only 7 per cent of research money allocated by the EU and the European Research Council in the past decade has gone to non-member states. It is not only the scale of funding that is significant, but the locomotive effect that resources have to drive collaboration and forge partnerships that allow our researchers to achieve more than they would achieve on their own. There is also a concern that UK partners will be given less opportunity by other collaborators due to a perception of not being fully engaged.

My fifth area of concern relates to the potential consequences of future trading arrangements entered into by the UK. The process by which any such agreements are arrived at must be fully transparent. No constraints should be placed on the devolved powers of this Parliament. I have two main portfolio concerns here. First, we share the concerns that have been expressed by many that any post-Brexit trade deals that the UK enters into must not open up our NHS to privatisation. On 7 February, the Prime Minister, at Prime Minister's question time, specifically failed to rule out opening up the NHS to competition. That cannot be allowed to happen. Secondly, we do not want to see post-Brexit trade deals being allowed to compromise the many public health benefits that we have realised in Scotland, such has in relation to alcohol and tobacco.

In conclusion, I can confirm that our assessments and preparations for Brexit are well advanced, but they are necessarily constrained by the lack of clarity about what EU exit will finally

look like. The challenge is complicated by multiple scenarios and uncertainty about the UK Government's objectives. In addition, many critical issues are reserved and the responsibility of the UK Government. We are seeking to mitigate some of the risks that we are facing by maintaining and strengthening our relationships with EU nations, through both the consular network here in Scotland and our office in Brussels. We are also upping our engagement with UK institutions that operate across Europe, ensuring that, come what may, Scotland will remain a progressive, outward-looking nation.

What I have presented to you this morning is by no means a comprehensive list of either my concerns or the actions that we are taking to mitigate some of the risks that we are facing, but I hope that it gives you a clear sense that we are alive to all the implications and challenges of Brexit and that we are doing what we can to mitigate risks that we did not seek and cannot avoid. I would be happy to take questions on all of those and any other related issues.

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

I will start with a general question about yesterday's agreement. Although it does not alter the substance of many of the issues that you have discussed, it potentially provides a wider window within which to resolve some of the issues. Is that the view of the Government? How does that impact on your areas of responsibility?

Shona Robison: I think that you are right to say that it provides a wider window but does not give any additional clarity. It provides more time, but it remains to be seen whether that time is used productively. We need to have certainty. Having more time is welcome, but the devil will be in the detail when it comes to what that transition ends up looking like. As I have laid out, we will continue apace in our work to secure Scotland's interests.

10:15

Emma Harper (South Scotland) (SNP): Good morning. Before I ask my question, I note that Lord O'Shaughnessy was invited to be here today. A sustained effort was made to accommodate his attendance, but he was unable to attend today or on various alternative dates that were offered, or to give evidence by videoconference. I find it interesting that another date could not be found.

Thank you for being here, cabinet secretary. You have outlined many of the issues that are faced as we proceed towards Brexit. I am interested to know what your immediate priorities for action are on the issues that you laid out. How is the engagement with the UK Government going as the process moves forward?

Shona Robison: I selected the five areas that I selected in my opening remarks—there are others—because, for us, those are the five most pressing matters. The issue of the movement of people is key here. We have many EU nationals working in our public services. Since the start of the process, we have tried to send out the message that they are most welcome here and that we want them to stay. We have tried to offer incentives and as much security as we have been able to but, ultimately, we cannot give guarantees—that is not within our gift. However, through some of the measures that I mentioned in my opening remarks, we have given a clear indication of our desire for them to stay.

Of the five issues, the key one for me is maintaining that flow of people for our health and social care services. We will continue to do whatever we can to ensure that the flow is maintained, but that is extremely difficult.

Emma Harper: Is there any way in which the Scottish Government can further health and social care integration? We are already pretty advanced with that, and social prescribing is being developed. Good approaches are being adopted. Will any of that be impeded by the UK's exit from the European Union?

Shona Robison: If you look at our health and social care workforce, you will see that there are various threats to it. There are more EU nationals in some medical specialities than there are in others. For example, there are higher numbers of EU nationals working in paediatrics and surgery. In parts of your neck of the woods, more than 40 per cent of dentists are from the EU. That is partly because of previous recruitment campaigns, as a result of which others were encouraged to come—there was a domino effect. Addressing that is going to be very difficult.

In social care, the impact is being felt in the here and now. We have heard from Scottish Care that getting care staff for care homes is a particular problem; it is also difficult to get nurses for care homes. The flow of such staff from the EU has been important. From what I have heard from Scottish Care, the recruitment agencies in Europe that it used to recruit people have essentially closed their doors because nobody was coming through them because of the perception that existed. That perception is as much of a difficulty as the reality. The fact that people are being put off coming here is a big worry, particularly for the social care field.

We will continue to take the action that we have set out in our workforce plans to grow our own workforce. We will do what we can, but we benefit from the diversity of the staff in our health and social care workforce. It brings a richness to our

workforce when people from elsewhere come to work here, and we do not want that to end.

Ash Denham (Edinburgh Eastern) (SNP): I am particularly interested in the negotiations. In its submission, the Scottish Government says that it is continuing to make representations to the UK Government on issues relating to health and social care. What level of involvement will the Scottish Government have in the Brexit negotiations?

Shona Robison: As you are probably aware, that has been a key point of contention. Because of our inability to take part in the negotiations, the information that we receive—if we receive any—is second or third hand. Therefore, we cannot set out our unique needs and aspirations in the way that we would want. The migration paper that has been written sets out clearly what would meet Scotland's needs in terms of migration policy, but for us to be Brexit ready and to be able to develop a migration policy that suits our needs, the UK Government would have to give the Scottish Government some of the powers on migration. Unfortunately, we have had no indication of any give in that direction.

We are in an extremely difficult position. We can foresee the impact and we know what it will be. We are trying to influence the outcome through Europe directly and, of course, through our negotiations with the UK Government but, as you have probably heard from Mike Russell and others, that has been a difficult process and not one that we have found productive. Unfortunately, unless things dramatically change, that might continue to be the case.

Ash Denham: As far as intergovernmental relations are concerned, are there structures in place to enable cross-Government working and to ensure that Scotland's voice is heard in the negotiations, or are you finding that you are not able to input into the process?

Shona Robison: There has been some co-operation on UK frameworks, particularly at official level. There have been deep dives into those issues and attempts have been made to find common areas of agreement. However, it is when we come to consent and the question of whether there is agreement that there has been a divergence of opinion to date. We believe that good progress can be made on UK frameworks, but the consent of the devolved Administrations is required, because many of the frameworks impact on devolved areas, as I laid out in my opening remarks. Without that explicit consent, we would be signing up to Westminster deciding on those frameworks, whether we like it or not, and neither we nor the Welsh Government have been prepared to do that, for good reason.

We have had endless amounts of discussion, but the key point about who ultimately decides has yet to be resolved. It is extremely important that it is resolved, because many of the areas in question are absolutely critical, as I have laid out.

The Convener: Thank you very much. That takes us to the key issue of common frameworks, which Brian Whittle will ask about.

Brian Whittle (South Scotland) (Con): Good morning. You have touched on the common frameworks work that is currently being done. What role do you think this committee, the Scottish Parliament and the Scottish Government might have in the development and agreement of common frameworks?

Shona Robison: All of our parliamentary institutions should have a role to play in that, and the committee has obviously attempted to get UK Government ministers to engage in the process. It is unfortunate that, so far, they have not agreed to do so. I think that they should.

There should be committee involvement, but we need to resolve the issue of consent. We can talk about frameworks and we can develop some of the thinking around them but, ultimately, we must agree on the principle of consent, particularly with regard to the legislation that will be developed to replace EU legislation. Not all of it will be contentious. However, it is vitally important that explicit consent is given by the devolved Administrations.

I think that that would create a better backdrop to and a better environment for the development of UK frameworks. We absolutely agree on the need for UK frameworks in many of the areas in question. It makes sense to have such frameworks, but there must be explicit consent.

Brian Whittle: I am interested in your input on what you think this committee would be able to do. We are going to produce a report on the impact of the UK's withdrawal from the EU on health and social care. We want to know what we can do to aid that process and to fit in with what the Scottish Government is doing. That is one of the reasons why we are asking for a dialogue to be maintained between us on the progress that you are making and what this committee can do.

Shona Robison: Any pressure that this committee or any other committee in Parliament can bring to bear to highlight the issues that I know that there is collective concern about around this table—I touched on some of those issues in my opening remarks—would be welcome. Brexit is a concern for all of us across the parties.

In addition, I hope that the committee can pursue the issue of the need for consent on the frameworks. We need to get that principle

established so that, when we get into the detail of what will be replaced, it is agreed that the agreement of the Scottish and Welsh Governments will be required. I think that there is a role for this committee to play in looking at some of the detail as it emerges, but we must get that principle established, as that will create the right backdrop to further discussions.

I am happy to keep the committee as informed as I can as the detail of these issues emerges. Now that we have an additional agreement on the transition period, I am happy to keep the committee informed of our on-going discussions.

Brian Whittle: It is also this committee's responsibility to hold the Scottish Government to account, including for the way in which the Scottish Government conducts itself in negotiations. That is why it is really important for the committee to understand exactly what the Scottish Government is doing in its interactions with the UK Government.

Shona Robison: As I am sure that you are aware, officials across all the framework areas have spent a huge amount of time and effort trying to move things forward. The deep-dive exercises and so on have taken a huge amount of time. There is no lack of willingness to engage on the detail, but we cannot get away from the principle that, ultimately, there must be consent on the matters that we are discussing.

I will make myself available as much as the committee wants me to over the coming period—I will come back here regularly to discuss the detail. We are trying to make as much progress as we can in many areas, but the fundamental issue of consent remains.

Sandra White (Glasgow Kelvin) (SNP): I want to develop some of the issues that Brian Whittle mentioned. I raised the issue of common frameworks in last week's meeting because it is very important. Obviously we need common frameworks for professional qualifications, organ donations, medicine prices and various other things. What discussions have been going on between the Scottish Government and the Westminster Government? It is a pity that Lord O'Shaughnessy is not here; we might have been able to ask him that question. Is there a date when we will hear whether frameworks have been agreed? It is very important that we have frameworks to cover these issues. Can you give us an update on where we are at the moment and when we will, hopefully, get an agreement on the frameworks?

10:30

Shona Robison: It is difficult to give a timeframe. We have timeframes that are set out externally that we have to work towards, and we are trying our best to make progress on the detail in our discussions. As I said earlier, there are many areas of agreement about what we need to establish and not all of that is contentious, but there are areas that are more contentious than others and areas where we would want to do things differently.

As I set out in my opening remarks, we believe that it is really important to have common frameworks on qualifications. Having consistency on regulations and qualifications allows people to work across these islands, and that is a good thing. There are concerns about the qualifications of EU citizens coming in; maybe Shirley Rogers can say a little bit more about that.

At the moment, it is a very straightforward process. If that was to change, I can assure you it would not be a straightforward process; for non-EU nationals coming in it is quite a complicated process, which we need to look at. We are attempting to do that, but we do not want to lose the straightforward process of EU national qualification recognition.

The detail continues to be discussed. We are doing that in good faith. Officials are spending a lot of time on this, as you can imagine. The political point at the moment is that if we are going to bring the discussions on frameworks to a successful conclusion and are going to be able to agree to them, there has to be a principle of consent to any of the legislative changes that need to be made.

Shirley Rogers (Scottish Government): I will bundle together answers to a couple of questions. At official level, we have been working very closely with colleagues in the Department of Health and Social Care, the Home Office and various other places. I meet regularly with my team and our opposite numbers in the Department of Health and Social Care to discuss a range of issues such as qualifications, reciprocity, pharmaceuticals and general preparedness, which includes preparedness for uncertainty by modelling various scenarios.

On the cabinet secretary's observations on the EU directive on recognition of professional qualifications, there are seven sets of professional qualifications that are given automatic read-across in the European Union. Five of those are germane to the health and social care world and cover doctors, dentists, midwives, general nurses and pharmacists. The other two, just for interest, are veterinary science and architects. The five that pertain to us are obviously germane to all of our workforce planning. I can assure the committee that we spend a great deal of time arguing very hard for the reciprocity of those qualifications to be immediately recognised. I am happy to give more detail on that if you wish, but I give absolute

assurance that those conversations are taking place.

The Convener: Cabinet secretary, in response to Ash Denham you mentioned migration and how significant it is in relation to workforce issues. Is that matter included in discussions on common frameworks, given the existence of, for example, Scotland's shortage occupation list and so on?

Shona Robison: Yes. The point has been made on every occasion that, to reference the "Scotland Population Needs and Migration Policy" paper, if we had those powers we could vary criteria and thresholds and decide what sits on Scotland's shortage occupation list. Those things—the ability to flex the system to meet our needs—matter. In the discussions we raise those issues and we make those asks. To date there has not been movement on that, but we will continue to make that case.

The Convener: Moving on to the implications for a specific area of the research workforce, we have heard strong evidence of the challenges that we will face in maintaining partnerships and collaborations. What specific areas have you have been working on with UK Government colleagues to enable such collaboration to continue? Going back to my very first question, horizon 2020 clearly is relevant here, and the wider window may have some benefits.

Shona Robison: There is a concern that that issue is having an impact here and now. Anecdotally—you have probably seen this in some of the submissions—people feel that there is already an impact on the success of research applications and that there is a feeling that we are over there now, and perhaps seen as a weak partner in collaborations. That perception matters, because it impacts on decisions being made now.

We all benefit from the research funding programmes. We are making the case very clearly to Europe that we want to continue to be part of that, and we are showing our goodwill and what we have to offer in research capacity and capability. We keep making the point that we are still open for business in that area and we want to be part of it. Of course, we are also making that point very forcefully to the UK Government.

Continued access to funding at levels at least equivalent to those currently available under EU programmes such as horizon 2020 is necessary to underpin research partnerships and collaborations with European partners in key areas such as dementia, where Scotland is a leading partner through the European prevention of Alzheimer's dementia consortium, led by a key academic from Edinburgh University and supported by the NHS dementia and neuroprogressive disease research network. There is a risk, as I set out in my opening remarks, that diminished international competitiveness and influence of the Scottish health research sector, coupled with exclusion from EU networks, may reduce the attraction of Scotland to potential research partners. For us, it is a key area where progress needs to be made, but, again, it is just part of the backdrop.

The Convener: I think that we understand how the informal networks and conversations that people have are influenced by their perception of what the outcomes of the Brexit negotiations might be. Given all those challenges, are there specific things that the Scottish Government can do to encourage and enable researchers from other EU countries to continue to see Scottish universities or Scottish scientists as partners and to provide assurance? Regardless of the progress of the negotiations at an intergovernmental level, are there things that you can do to assist Scottish institutions?

Shona Robison: The Scottish higher education institutions have secured over €316 million under horizon 2020, up to September 2017, based on their world-class research reputation. We continue to promote that world-class research reputation around Europe and the point that Scotland is still open for business in research is being made all the time.

However, I started off saying that we cannot get away from the fact that there is awareness in the research field that some programmes are going to take place through the transition period and beyond. That is a difficulty for us, but we continue to promote Scotland's ability, skilled workforce and reputation, and we are doing that as forcibly as we can.

Shirley Rogers: I think that the convener's question is about what we do about the rest of the world, not just the EU component. That leads us to the conversations that we have already embarked on about what migration policy might look like and where we might seek flexibilities on UK visa regulations beyond Brexit, and how that would allow us to attract and work with the rest of the world, as well as with those partners from Europe. Those conversations include such things as the existing tier 2 visa arrangements and the kinds of visas that might apply for people in training. They also include our concerns about things such as the immigration skills charge, and how that might be a disincentive to people coming from overseas and perhaps not as effective as it might be in helping us to secure our medical workforce. There are a number of issues that go way beyond the relationships with Europe. There is no doubt that Scotland's attractiveness with regard to the ability to secure funding across Europe has been a concern.

David Stewart (Highlands and Islands) (Lab): I am sure that you are aware that one of the positive things about research in Scotland is that Scotland is a net beneficiary in relation to research and has more spend per head than any of the other EU28 countries. What is your view about us becoming an associate member of horizon 2020? I am sure that the cabinet secretary is aware that there are non-EU countries that are members of horizon 2020, albeit non-voting members.

Shona Robison: All of these possibilities are actively being pursued. Obviously, we want to continue to be full members and have access—that would be our first choice—but we are looking at what the other options might be. All the options are being explored. The closer we can align ourselves the better, which is why ministers have been spending so much time speaking to institutions within Europe, including research institutions, looking at what those options might be and showing willingness to explore them. Again, I am happy to keep the committee updated as those discussions and others continue.

The Convener: We will come back to research issues in a moment, but first, Miles Briggs has a question on workforce issues.

Miles Briggs (Lothian) (Con): The Convention of Scottish Local Authorities noted in its submission:

"Even before taking Brexit into account analysts and commentators foresaw significant challenges for all sectors".

Specifically, I want to look at the situation regarding Scottish home-grown medical professionals. In terms of workforce planning over the last decade, where do you see changes happening within the social care workforce and the medical schools in Scotland, for example, to meet future demands?

Shona Robison: Since 2016, 190 medical school places have been added and we have continued to expand medical education, and not just at undergraduate level—the new graduate level medical school is opening its doors this year—in order to build more resilience and robustness around growing our own workforce. We have taken those steps and we are expanding training places. We have made a commitment to have 2,600 additional training places for nursing and midwifery by the end of this session of Parliament.

We have set out plans to try to make social care more attractive as a career; the workforce plan sets out a number of mechanisms and ways of doing that. We are doing all that, but we also have to recognise that we benefit enormously from people who come to study here, who make their home here, and who contribute to our public services. That in itself is a very rich seam of talent and experience that we do not want to lose.

We will take and are taking steps to grow our own workforce, but we benefit from people coming here, and not just in relation to the number of people working in our public services; there are also all the cultural benefits that we get from people coming to work here.

Our medical schools have had an international reputation since they were established and we have more medical schools per head of population than anywhere else in the UK. Part of the benefit of that international reputation has been that people want to come and study at them. Many of those people stay and some go back to their home countries, but without a doubt our medical education system is world renowned and we want to make sure that it remains so.

10:45

Miles Briggs: On that, the number of Scotland-domiciled medical students has gone down by 12 per cent since 2000. There has been a decision to cap the number of places that are available for Scotland-domiciled students, so now only 51 per cent of medical graduates are Scotland-domiciled. In 2000, the figure was 63 per cent. Will you consider lifting that cap, given what you have said about growing the medical workforce and projecting future needs?

My second point is about adult social care staff. We have taken a lot of soundings on that issue for our report. How many adult social care staff do you think Scotland will need because of Brexit, and what is being done to ensure that the college sector is helping to prepare for those posts?

Shona Robison: Universities have always had the ability to recruit freely to their medical places. That ability has been important in ensuring that our five medical schools continue to be world leading and to be seen as international medical schools.

On expanding the number of places, 190 medical school places have been added since 2016, with the intention to create more opportunities for Scotland-domiciled students. You will also see from the graduate medical school programme that we have offered bursaries to people for committing to working in the NHS—no matter where they come from. It is about them wanting to work in the NHS. That bursary is a motivating factor and it offers people an opportunity to commit to the NHS; we believe that many will do so.

Shirley Rogers: This also relates to Mr Whittle's question about what the committee can do. Granularity about the evidence is sometimes

helpful. If we take the 1,177 doctors in 2017 with European primary medical qualifications—those who qualified in other parts of the European Union—at the moment, the dispersal across our specialities is quite uneven. That becomes very important when we are looking at the impact of withdrawal from the EU. I highlight general medicine, emergency medicine, anaesthetics, intensive care, occupational medicine, ophthalmology, paediatrics, pathology, radiology, and surgery. We have been able to nuance our training places in those specialities. To take paediatrics as an example, rather than training one paediatrician for every paediatrician we think we will need, in order to reflect the changing nature of the workforce, we now train people at a ratio of 1.6:1.

There are a number of things that we can technically do to try to encourage students to train for specialities that we particularly want to see more people going into. It is not simply a matter of saying that we want an overall increase in the numbers: we want to target the specialities that we need. Those of you who have sat around the committee table for a while will recognise that that list is not dissimilar to the list in our workforce plan of specialities in which we want to see expanded numbers in any event. We want to grow the number of paediatricians, radiologists and so on.

Migration policy becomes very critical in respect of healthcare support work and social care, not just in relation to the EU but in relation to the world. Of course we need a points-based system so that we can to recognise highly technically competent people who come from medical or other backgrounds. We also need something that gives us access to people who do not have such backgrounds. We want to be able to attract people who have high-level skills and we want to attract other people as well.

To come back to what we have done, I note that we have introduced training to grow our own healthcare support workers in a programme that was developed in conjunction with the Scottish Social Services Council and NHS Education for Scotland. That allows us to take people who have virtually no educational qualifications and train them to a professional level in healthcare and social care. The number of those people is growing every year.

Shona Robison: We are also looking at having a clearer pathway for people who have come in through that route and might want to go on to a regulated profession. They should be able to have a clear line of sight to that profession and more flexibility. The workforce plans set out a lot of the detail about how to elevate social care as a career choice and marketing of that. There is a lot of detail about what we are doing, which we would want to do anyway, but in the light of Brexit, there is an even sharper need, given the evidence from Scottish Care about the reliance on nurses from the EU working in nursing homes.

One of the things that we have been exploring and working on with Scottish Care is the idea of using NHS nurses in nursing homes where it has been very difficult to recruit. Nursing homes are having to pay exorbitant agency costs, which is not sustainable. I think that NHS Dumfries and Galloway will be one of the first areas where we trial that. Please be assured that we are trying many and varied things to try to make those professions more attractive.

Brian Whittle: This follows on from Miles Briggs's questions. I raised this point at a previous meeting. A couple of people came into my surgery saying that they had the qualifications to get into medical school but could not get in because places were not available. Has any research been done into the number of people who are in that situation and whether that may be a resource that is yet to be tapped into?

Shona Robison: We have done a lot of work on widening access to medical schools. You are probably aware that there are 11 suitably qualified applicants for every place. Beyond qualifications, the issues that come into play in respect of who gets the place are often to do with how people perform at interview, or their work experience.

If a person has relatives who work in medicine, they are more likely to get into medical school because they have been able to access that circle of people and to get workplace experience that others might not have been able to access.

The widening access programme, which Shirley Rogers has been involved in, has been looking explicitly at how to make sure that people get a better chance of securing places—in particular, people from more deprived backgrounds. The pre-medical year initiative has been very successful. I have met young people who have been taking part in that, and who are from a wide variety of backgrounds. That is all about trying to make sure that everybody gets a fair crack of the whip in accessing medical education. I think that it is showing some signs of success.

Shirley Rogers: The pre-medical year was introduced in 2017 and was full, with 40 pre-med students. The early indications are that those students are likely to go on either to medicine or to some other healthcare-related science qualification, so we are optimistic about that.

Brian Whittle: You say that there are 11 applications for every place, so there is potentially an untapped resource.

Shona Robison: Yes, but the question is why, out of those 11 applications, it is often young people from more-deprived backgrounds who are less successful in securing places, even though they have the highers and tick all the qualification boxes? The research and evidence shows that it is about the wider application process—the interview, for example, and the wider work experience that the person might or might not have had in a medical environment.

A person from a family in which there are people who work in medicine is more likely to be able to put such work experience on their CV. The pre-med course tries to level the playing field and gives young people who do not have access to such support an opportunity to get that experience prior to—

The Convener: These are important matters, but I am keen to press on.

Shona Robison: We can provide the committee with more detail on that.

The Convener: I am sure that we will return to the subject at some point, but there are specific Brexit questions that we want to cover in the time that we have left.

Emma Harper: When Joanna Macdonald from NHS Highland gave evidence, she talked about the challenges that Brexit will bring for remote and rural areas, and about the fact that the central belt is a draw for people who are going into education or medical school. I am interested to know what the Scottish Government can do to promote or to help remote and rural areas. It would also be interesting to hear a wee bit more about graduate entry to medical school. I spent the weekend at Wigtown, Port William and Newton Stewart, and people say that those areas might as well be islands because they are very rural.

Shona Robison: One of the examples that I gave earlier was the potential huge challenge in dentistry. It is not the case now, but there was a time when there was an acute shortage of qualified dentists, so there was a European recruitment campaign, which was very successful, particularly for our rural areas. Many EU dentists came to work in Dumfries and Galloway, the Borders and the Highlands, and they have stayed and encouraged others to do the same. We need to be alive to those pockets of success, but we now have a particular challenge, so there has been direct engagement with those professionals around trying to encourage them to stay. Many of them have brought up their families here and they want to stay. That is an acute example.

On what we are doing on remote and rural, you will be aware of ScotGEM—the Scottish graduate entry medicine programme—and the rural health boards have been proactive in securing training opportunities in their areas. Down in Emma Harper's patch, NHS Dumfries and Galloway has been quick off the mark and has made a commitment to take a number of trainees from the graduate medical school, in particular in general practice. That will make a huge difference not just because of the numbers of trainees, but because they will get experience of working in remote and rural Scotland. I hope they will therefore want to do so on qualification, once they have finished their training.

I guess that all the impacts that I have mentioned—Shirley Rogers touched on some of the speciality posts that are harder to fill, for which we draw from the EU—are exacerbated and highlighted more in rural and remote Scotland. We will continue to do what we can with the trainees. In radiology, for example, we are increasing the number of trainee places and we are trying to ensure a spread of those, particularly to areas where there have been particular challenges in recruitment, such as the north of Scotland.

Shirley Rogers: I will amplify some of the cabinet secretary's comments. One of the issues that we need to face in relation to dispersal and how we train across Scotland is that people experience a different kind of medicine in remote and rural Scotland from what they experience in the central belt. In remote and rural Scotland, we do not have big teaching hospitals where people go to do heart or lung transplants. It is about how we value general practice and give it parity of esteem.

It is for that reason that the design of ScotGEM, for example, not only incorporates work from the University of the Highlands and Islands but has a huge focus on general practice. Historically, medical schools designed medics who were destined for specialties. It is a bit of an oxymoron, but our view is that general practice is, in itself, a specialty, so it is really important that we invest in it.

Graduate medical schools are designed to focus on people who have already been through a degree qualification, are a bit more settled in their lifestyles and are choosing to live and work in a particular location. That is another aspect that I want to pick up on. All the evidence that we have suggests that, wherever they come from around the world, people want to live in rural Scotland because they are making a lifestyle choice. They want to locate their families in rural Scotland and experience the lifestyle benefits of living and working in rural Scotland, so uncertainty about whether they will be able to continue to do that is a really big issue.

The Convener: Shirley Rogers mentioned a specialism in which a calculation has been done on how many people we need to train. What is the

scale of the social care workforce, the nursing workforce and the general healthcare workforce that we need to plan to recruit in order to compensate for the likely loss of many of our European Union colleagues?

11:00

Shona Robison: One of the reasons why we expanded the nursing and midwifery training places to the committed 2,600 places by the end of the current session of Parliament was that we have an eye on Brexit and other challenges, and on the need to expand that workforce. Also, the nursing workforce is expanding anyway because of roles that nurses are taking on, and we need more nurses for the multidisciplinary teams in primary care. We have calculated as best we can. The expansion of training places is a big commitment: it is a £40 million commitment to grow that workforce, which we hope will also help to mitigate the effects of Brexit.

On the social care workforce, again, the workforce plan sets out the scale of the challenge. We need to encourage many more people to work in social care. The workforce plan sets out how we are going to work to change the perception of social care and how we are going to attempt to recruit and create more career opportunities and clear pathways to, for example, regulated professions. We need to do all those things to grow the workforce.

The Convener: I appreciate that you may not have numbers to hand, but perhaps Shirley Rogers can assist.

Shirley Rogers: I can supply some numbers. In 2017, there were 762 EU-qualified nurses and midwives operating in the NHS in Scotland, which represents approximately 1.76 per cent, so we would need to increase by that factor in order to stand still.

The data that we have on the social care workforce is a bit more fragmented, for obvious reasons. However, to put a quantum on it, I note that 4.4 per cent of the social work cohort are EU qualified and a further 2.4 per cent are from other parts of the world, so a total of 6.8 per cent of the cohort is from outside the UK. The estimate that we have from the independent care home sector is that the figure is approximately 8 per cent. We would need to increase by approximately those percentages in order to stand still.

The Convener: Thank you—that is helpful. Jenny Gilruth has some questions on research funding.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): I thank the cabinet secretary and Shirley Rogers for coming to speak to us this morning.

I want to start by looking at public messaging. We have already touched on this but, in last week's evidence session, I mentioned the intervention that the UK Government's chief whip made when he wrote to every UK university regarding the teaching of Brexit and having the names of those who were delivering the syllabus. That sent a pretty clear message, and I have to say that Lord O'Shaughnessy not even bothering to turn up today or to respond to the committee's request also sends a pretty clear message on how this Parliament is seen within the negotiations.

Anyway, in response to my questions last week, Professor DAme Anna Dominiczak told an upsetting story about being asked by a colleague, after the Brexit vote, whether she would now go home. Scotland has been her home for the past 36 years. I asked her whether we are in danger of losing our academic edge post-Brexit. What is your view on that, cabinet secretary?

Shona Robison: I know Anna very well and she is a great asset to us, as are many of her colleagues. She works extremely hard to promote Scottish research and she has been incredibly successful in bringing huge numbers of research opportunities to Scotland, so she is a real credit to us.

The unfortunate backdrop to this saddens me. We have seen recent statistics about the rise in intolerance and in comments and racism towards people from the EU on the back of the leave vote. It is sad, upsetting and abhorrent. It is not where we want to be and it is not the kind of Scotland that we want to be. We are not immune to it, and we have all heard of such incidents, whether from Anna Dominiczak or from others. That is the very sad fallout from this.

We have to work very hard to make sure that we continue at every opportunity to give the message that Scotland is an outward looking and welcoming nation, and that we want people to come and work and make their homes here, as Anna Dominiczak has done for many years and has encouraged others to do. We feel extremely strongly about that, and that message, which we can all give out, is important. It is important to reassure people such as Anna that the comments represent a minority view and are not shared by the vast majority of people here.

On what we can do about it, I mentioned earlier the welcoming nation message, but we also have the hard edge of wanting to ensure that we continue to keep the dialogue open with EU institutions and research institutions. We have a lot to offer here. We stand on our own merits, in many respects, in terms of what we have to offer in the research world. Often, our skills are not found elsewhere, whether they are in the life sciences or in the growing data skill set that we

have in Scotland. However, we are going to have to work hard to keep that message out there and to counter some of the negativity that has grown up around the issue.

Shirley Rogers: May I pick up on the messaging? Reassurance is terribly important, as is the nature of Scotland as an inclusive society, but I think that people are also looking for certainty. As recently as yesterday, I was speaking to a couple who are consultants in one of our health boards, and I heard about their having already decided to move to North America, because although they have enjoyed their training here, they enjoy working here and they are quite happy here, they know what they have to do to be able to stay somewhere, and they are at the stage in their lives where they want to think about having a family.

The message is terribly important; people want to make their lives in a place and they need to know that they can do that, and they want to know the rules, whatever those rules are.

Shona Robison: Yes. As I laid out in my opening speech, we have tried to give incentives. We have said that we will pay the fees for anybody who wants to apply for settled status, and that we will continue to pay tuition fees. That sends out a real message, but I should also have mentioned that Dr Peter Bennie was spot on when he said:

> "The Scottish Government has been clear that it wants to protect the rights of European NHS staff and this is welcome and appreciated by many, but it is ultimately the Westminster Government that must act before further damage is done."

That captures what both Shirley Rogers and I have said. We can put the message out, but we need action to end the uncertainty.

Sandra White: I have a couple of questions on the research workforce. I concur with everything that Jenny Gilruth and the cabinet secretary said about retaining people and making sure that people want to come here.

A cap was mentioned earlier, but there is also a current cap on the number of non-EU residents who are able to come here and work in the UK. Are we looking at anything in that respect?

Shirley Rogers: I want to go back to Mr Whittle's question about the numbers of medics in training. I am sure that, if I was sitting in your seat, I would be thinking, "There are lots of applicants and we only take a certain number of them. Why do we not just take more of them?" Last time we looked at the evidence, about 47 per cent of our medical establishment were doctors in training, so we always have to balance the issues about making sure that those doctors in training are getting a good medical education, and we rely on our consultant workforce to do that.

Those of you who know medical education well will know that some of it is spent in the classroom, but an awful lot of it is not—it is spent on the wards with supervision by our consultant and senior training workforce. There is always a balance to be struck. Even if there was all the money in the world and all the interest in the world, we could not simply say, "We're going to have an extra 10,000 doctors arriving tomorrow", because there would not be a process in place to give them a good-quality education and well-supervised educational practice to ensure patient safety.

We are always open to suggestions about how we can increase supply to our medical professions, and we are always looking to do that. There is a model that the universities use for places that are funded through Scotland, places that are funded through the rest of the UK and places that are funded through the rest of the world, and the universities have discretion to move somewhere along that line. In particular, we have funded and targeted funding to access places for Scotland-domiciled students. It is not for us to tell the University of Edinburgh that it cannot take X or Y students, but by the same token, it is terribly important to try to encourage people from Scotland to go into Scottish medical schools.

Sandra White: The point that I wanted to make was with regard to the cap on non-EU students and researchers coming here. Is that something that the Scottish Government can look at or is it a UK-wide thing?

Shona Robison: It comes back to the visa situation. The migration policy sets out that we would like to have more flexibility and discretion around that for the skills and occupation shortage list. We have tried to forge some of our own initiatives, not so much on the research side, but on the medical training side. For example, the medical training initiative is an opportunity for people at the end of their training—in their last two years—to come and finish their training here. We have been discussing with Malaysia, for example, which has a similar medical education set-up, that we would take some of its trainees to finish their training, particularly in the specialties that are hard to fill. Those are people with a high level of skill, as they are at the end of their training, so they are really worth their weight in gold. We are looking at how we would create those opportunities beyond Europe.

In research, we can have discussions when our ministers go out to speak to their counterparts in countries that we have been targeting around our international engagement. Research will be very much at the top of the list in relation to trying to forge new interests, new businesses, new alliances and new investment. Europe is critical,

but we have other plans and engagement across the world, and we have been trying very hard to bring jobs and research here to Scotland and to forge those links. We can furnish you with more information if that would be helpful.

The Convener: Other members wish to ask about the topic, so we will maybe come back to them, if time allows. I would like to make sure that we do not miss other key issues.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, and thank you for coming to today.

An area that I had not considered—I doubt whether other committee members had, either—is the impact on clinical trials of leaving the EU. We understand that for ultra-orphan conditions, for which there are too few patients in Scotland for sustainable clinical trials, we use pan-EU trials. My colleague, Jenny Gilruth, has mentioned the testimony of Professor Dame Anna Dominiczak, and I would like to do so, too. Professor Dominiczak referred to it as being "almost ... criminal" if the shocking reality is that Scottish patients are ripped out of EU clinical trials. What representations have been made, in discussions with the UK Government about a future Brexit trade deal, on our continuing to be part of some kind of clinical trial agreement, and about any mitigation that we can put in place to reduce the impact on Scottish patients so that they are not deprived of potentially life-saving therapies?

Shona Robison: Alex Cole-Hamilton has raised a hugely important point. The UK Government's stated commitment is to continue close working and collaboration with the EU, through the Europeans Medicines Agency and the EU clinical trials portal, but what does that mean?

11:15

We want access to the EU clinical trials portal. We can ask for the moon and say we want to do whatever, but making it happen is another matter. Anything short of access to the EU clinical trials portal will be a disaster: we need absolutely to secure that. We have been working hard on the issue with the UK Government. You would not, I suspect, hear much disagreement on the matter from the Department of Health and Social Care or from Jeremy Hunt, but he is not one of the key Brexit negotiators. Therefore, we need to make sure that the issue is up there. Mike Russell has been well-briefed about the matter—he knows the importance of access to the EMA and the EU clinical trials portal. We continue to highlight its crucial importance, and have done that directly to Europe as well by making very clear in the UK Scotland's desire to continue to be part of the system.

However, as I said in my opening remarks, there is limited experience of that in respect of countries that are not part of the EEA, which might be described as their having their cake and eating it. I think that is the difficulty. We need to use every lever we have to secure continued access. We have a lot to offer: Scotland's ability in clinical trials and our offering, based on the unique selling points of our NHS, are well understood.

However, that is one item on a list of many critical issues. Alex Cole-Hamilton is right that we need that wider access to patient information in testing of ultra-orphan drugs. We will require access to EU clinical trials portal.

Alex Cole-Hamilton: It strikes me that this is a world away from the trade discussions about dealing in cars, whisky and the rest of it. Lives will depend on what happens. Is the Scottish Government in a position, while the arrangements are being ironed out, to keep pace with the European clinical trials directive, through making sure that our standards mirror those of Europe so that we are ready to re-engage if we are ripped out of the system? Are there other international trials networks that we could take part in if Europe is closed off to us?

Shona Robison: Yes—there are other international clinical trials and we already take part in them. Many trials can now, through technology, go far and wide. We can write to the committee with more information on that. We absolutely want to align and that is our intention, but obviously the UK framework discussions are part of this, in that what would make most sense is for us to agree UK-wide to align and to adopt frameworks, and to adopt the high level and very well understood regulatory commitments and quality assurance that are so important.

Again, all that is caught up with the issues that we discussed earlier about frameworks, and the need for us to agree them and to do so freely across these islands. Discussions continue.

David Stewart: I will ask about medicines and treatment, which the cabinet secretary touched on in her opening statement. I am very interested in and concerned about the future in respect of medical isotopes. The cabinet secretary will be well aware from her own knowledge and from last week's evidence at the committee that the UK produces no medical isotopes, and is part of Euratom, which regulates import and export of such isotopes. I point out that 90 per cent of world production of medical isotopes is in four EU countries, Australia and South Africa.

Obviously there are huge concerns about medical isotopes, because they are used, as you know, to prevent surgery, so lack of security of supply of those isotopes will mean problems:

longer waiting lists, more costs and more surgery. What assessment have you made of the effect on cancer patients in Scotland of the UK leaving Euratom?

Shona Robison: Specific work has been done on that. I will be happy to write to the committee with the detail. It is a huge concern and I am glad that David Stewart has raised it. You can imagine the situation if there were to be customs delays with medical isotopes being caught up at the border: it would have a huge impact on treatment.

It is not easy to secure alternative supplies of medical isotopes. They are very particular products whose transportation has to be done in particular ways and has to be done safely. That, too, has been raised by officials, and by Mike Russell in his discussions with me.

We need clarity. We raise the issues and we talk about the impact, which would be an impact across the UK, and not just in Scotland. However, we have yet to get a clear route to resolution. The matter is a particular concern.

You can imagine that there would be real concern about any goods and services being delayed at customs points, but the impact in this case would, as David Stewart said, absolutely be on patient treatment, which cannot be allowed to happen. Again, we will be happy to keep the committee updated on the detail and progress, as discussions move forward.

David Stewart: I am sure that the Government has a risk register of potential threats and I am sure—this is a comment rather than a question—that you will add to your risk register the fact that medical isotopes have a short half-life and cannot be stored.

Shona Robison: Yes—absolutely. We can see very clearly what the impact would be of medical isotopes being kept at the border because of customs delays. The matter is high on the risk register.

David Stewart: You touched in your opening statement on the UK leaving the EMA. What is your assessment of the effect of that, and how realistic is our becoming an associate member?

Shona Robison: As I said in my opening remarks, there is no precedent for our becoming an associate member as far as I am aware, so that, too, is uncharted territory. It is not something that has been done.

The issue is—you will have heard the pharmaceutical industry express this very forcefully—that there is understood quality assurance in which standards are clear. Let us say, for argument's sake, that a UK alternative to that is developed. In that case, there could be questions about quality assurance. Would that alternative be pegged to the EMA? Would it have the same standards? Those questions remain unanswered. How widely understood would the system be by international pharmaceutical companies that understand well the standards of the EMA? They might not understand the new thing that people are telling them is pegged to EMA. Will it be? We do not know.

There are huge risks, because the pharmaceutical industry can go anywhere in terms of where it invests, clinical trials and access to medicines, so we need to have standards that are internationally understood. That is, in my view, best served by the EMA, because everybody understands it. Again, we continue to discuss the matter, which we have been doing in discussing the framework. Shirley Rogers will give more detail.

Shirley Rogers: I will amplify the cabinet secretary's comments by talking about licensing. There being a supply of a thing and being able to get it timeously is one thing, but there is also the cost and licensing arrangements among countries. If we look at some of the biological drugs that are currently available, we see that there are different pricing regimes in different countries depending on where the drugs are in the licensing cycle, so there are drugs that are considerably more expensive when they are sourced from outside the EU. There may also be drugs that are cheaper when sourced from elsewhere, but the majority of new biologicals and so on are still largely under licence. The situation will be very dependent on cost and licensing arrangements.

David Stewart: I am conscious of the time, so I will, with the convener's permission, move on to reciprocal healthcare.

The cabinet secretary will be well aware that there are two main cards, which are positive, for citizens of the EU and the EEA. There is the European health insurance card, which all citizens can access, and which gives every citizen in the EU 28 the same rights—as it does for citizens of Norway, Iceland, Lichtenstein and a few others.

There is also the S1 arrangement, which provides free or low-cost healthcare for people who are in receipt of a state pension, which is obviously crucial for people who decide to move from Edinburgh to Italy, Spain or another EU country. It also provides great advantages to people who have medical problems; for example, 29,000 UK dialysis patients are able to go abroad. If they did not have that access, there would clearly be huge medical insurance costs, which might not allow them to go.

The main issue that I want to raise is, again, risk registers. If the S1 reciprocal arrangement does not come to fruition immediately, what will be the

impact in respect of Scots living abroad who are of pension age coming back to Scottish healthcare to access primary care, social care and care homes? Have you estimated the possible impacts of that on your budget and your hard-pressed front-line staff?

Shona Robison: If all Scots of pensionable age living in Europe were to come home at the same time, of course that would have a huge impact. Human behaviour is not quite like that, however.

First, I say that we hope that reciprocal arrangements will finally be worked out and agreed, because the scenario that David Stewart describes would not be in anybody's interests. For people who have made their lives abroad for many years, on the Spanish coast or anywhere else, we want to try to reach agreement. I expect the UK to be working very hard on that. We know that the reciprocal arrangements have been a key priority. However, we want to ensure that we do the work to assess the flow of people who might return. We are not, at the moment, getting any indication that there will be a mass flow back of Spanish coasters. I think that people are waiting to see what transpires; they are probably picking up messages that guaranteeing reciprocal rights has been a priority area for the UK Government.

The S2 and S1 schemes bring—as David Stewart has set out—considerable benefits to people in terms of their being able to travel, so I hope that there will, as part of the transition period agreement, be something in that space. The worry is the uncertainty. At the moment we do not know what will happen, but we know that the subject is a priority that has been discussed. We would want our citizens to continue to have access to those rights following the UK's withdrawal from the EU, but we need the detail to emerge.

I do not think that there will be a mass flow back to Scotland overnight of people who have been living elsewhere, but there is a risk in people not having certainty in terms of decisions about their future.

11:30

David Stewart: The cabinet secretary may well have seen the excellent report "Brexit and the NHS", by the "The UK in a changing Europe" initiative, which has been provided to the committee. As you know, that report is independent. It suggests that there are 190,000 UK citizens over the age of 60 living abroad and that, if they came back, we would need 900 more care beds. Do you recognise these figures?

Shona Robison: Yes, we do. That is a key concern. I would hope that agreements would be put in place before that, but people need certainty. At the moment, I think that people who have retired to enjoy the sun somewhere will be worried about what the future holds. We need certainty now, before people begin to make decisions about where they are going to live. If everybody decided to come back, and no arrangements had been made, there would be a huge impact on our health and care services.

David Stewart: I am also concerned about the possible effect on those who have long-term illnesses or who are elderly. Their ability to go abroad will be restricted—particularly those who have a lower income—because, without the EHIC card, health insurance will be beyond them.

Shona Robison: That is undoubtedly the case. Some people already have issues with securing health insurance if they have a long-term condition or are acutely unwell. I am concerned about that.

The current arrangements benefit our citizens when they are travelling, but they also benefit citizens who travel here. They are a sensible set of arrangements that will need either to be kept in place or to be replicated in some way. I do not see how we could operate our systems without such arrangements being in place. As I said earlier, I hope that that situation will be resolved. If it is not, we are leaving ourselves open to a huge impact on our citizens—those who are here and wish to travel, and those who are living abroad and wish to remain there.

Ivan McKee (Glasgow Provan) (SNP): I thank the cabinet secretary and Shirley Rogers for coming to talk to us. With all the issues that you have to manage in the health service, given the ageing population and so on, the last thing that you need is all the additional problems that are caused by Brexit coming along to make things more difficult. I echo other members' comments—it is a shame that nobody from the UK Government is here to discuss its position, despite the fact that they were invited and were given many options for different dates.

I want to focus on the potential impact of future trade deals on health and social care. In past sessions, we have heard evidence, as you will have seen, that hard Brexit trade deals could restrict the Government's ability to take forward public health policies. There are areas around tobacco, alcohol, challenging obesity and so on in which the Scottish Government has distinctive policies that we would want to take forward. However, if we are in a transatlantic trade and investment partnership-type deal, we could be dragged into a situation in which we are unable to pursue those policies. Do you recognise those potential challenges? Given that we are still in negotiation with the UK Government about where we end up, what can be done around whether there will be consent for common frameworks and what might that situation look like?

Shona Robison: You are right in saying that Brexit adds in spades to the challenges that we already face and which we are trying to address, particularly in the workforce. It is a far cry from the leave campaign's claim that it would benefit the NHS by £350 million a week. The worry list includes future trade deals, and we would not want to see included in any such deals any mechanism, such as an investor dispute mechanism, that would allow private companies to take Governments to court or to a tribunal to prevent them from implementing public health measures that they felt would damage their businesses. Again, we have tried to seek assurance that any post-Brexit trade deals that the UK enters into will not open up the NHS to privatisation or endanger public health initiatives.

Vince Cable attempted to get the Prime Minister to rule out opening up the NHS to competition, but unfortunately she did not do that. She said:

"We are starting the discussions with the American Administration, first of all looking at what we can already do to increase trade between the US and the United Kingdom—even before the possibility of any free trade agreement. The right hon. Gentleman does not know what the American Administration are going to say about their requirements for that free trade agreement. We will go into those negotiations to get the best possible deal for the United Kingdom." —[*Official Report*, *House of Commons*, 7 February 2018; Vol 635, c 1492.]

I do not think that that gave any assurance that the Prime Minister—or the UK Government—would be setting out with a clear ambition to have red lines around these issues. The frameworks will be very important in enabling Scottish interests and requiring consent around those issues. If that does not happen, we can envisage a scenario in which, despite our opposition, the NHS could be opened up in that way through a trade deal that did not have the explicit consent of Scotland or Wales—I know that the Welsh have written to the Prime Minister, as I have, to express concern about this issue and the lack of commitment in her response. You can see why consent is so important; without it, there would be a risk that the NHS in Scotland and in Wales could be opened up in the same way, depending on UK Government policy on that matter. I do not think that anyone wants to take that risk; that is why consent is so important.

Ivan McKee: Thank you for clarifying that. The danger is that people often see our debates about common frameworks, Brexit and the continuity bill as being about something abstract, so it is good for our discussion to be firmly rooted in things that are very important to people in their everyday lives and in an area as important as the health service.

The Nuffield Trust felt that it would certainly be possible to limit sectors or geographies if the UK Government was going forward with trade deals internationally, but as we have said that would very much depend on it signing up and allowing consent to the common frameworks. The Nuffield Trust also made the point that the health service in the rest of the UK was significantly more "marketised"—that was the word it used—than it is in Scotland. Is there a risk that there could be significant pressure from those trade deals for Scotland's distinctive health service to become more like the health service of the rest of the UK, with all that that entails?

Shona Robison: Our policy towards the NHS is very clear. We would absolutely resist any attempt that was made to do that. We would not want that to happen to our NHS in Scotland, and we would do everything possible to avoid that happening. The best way of guaranteeing that that will not happen is for us to require an explicit consent. As I said, the Welsh are of the same mind as us when it comes to protecting the NHS from elements of trade deals that would be against the ethos of how we run our NHS. We would resist very strongly any attempt to do that.

The Convener: Looking beyond 2020, it is clear that there are many things that we cannot know about the landscape. Has the Scottish Government begun work on, for example, the replacement of research funding or the anchoring of life science companies in Scotland beyond 2020 if we do not have the optimum outcome to the negotiations that you have described this morning?

Shona Robison: Yes. As you can imagine, a lot of work is being done on scoping various scenarios. As someone once said, we are dealing with unknown unknowns. For the things that we know about, we are working hard on what we anticipate will happen; we are working with Europe and internationally on looking at other opportunities. We are scenario planning around a number of options, given that there are so many unanswered questions, as this session has brought out. We will do our absolute best to ensure that we protect our interests, whether that is on research, on the NHS or on the workforce challenges, to make sure that we mitigate the impact as far as we can. However, that will be extremely hard to do.

The Convener: I thank you both very much for your attendance. We will now move into private session.

11:40

Meeting continued in private until 12:28.

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