OFFICIAL REPORT
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Health and Sport Committee

Tuesday 19 January 2021

Session 5

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Pàrlamaid na h-Alba

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HEALTH AND SPORT COMMITTEE
2nd Meeting 2021, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Donald Cameron (Highlands and Islands) (Con)
Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Tim Allison (NHS Highland)
Pam Dudek (NHS Highland)
David Garden (NHS Highland)
Professor Paul Haggarty (Scottish Environment, Food and Agriculture Research Institutes)
Professor Boyd Robertson (NHS Highland)
David Thomson (Food and Drink Federation Scotland)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Tuesday 19 January 2021

[The Convener opened the meeting at 09:30]

Scrutiny of NHS Boards (NHS Highland)

The Convener (Lewis Macdonald): Good morning, and welcome to the Health and Sport Committee's second meeting in 2021. We have received apologies from Alex Cole-Hamilton.

I ask all members and witnesses to ensure that their mobile phones are on silent and that all notifications are turned off during the meeting. Our first agenda item is an evidence session as part of our scrutiny of health boards and special health boards; today, we will hear from NHS Highland. I welcome to the committee Professor Boyd Robertson, who is chair of NHS Highland; Pam Dudek, who is chief executive; David Garden, who is director of finance; and Dr Tim Allison, who is director of public health.

We move directly to questions. I start by asking about the impact of Covid-19 on the on-going challenges that NHS Highland and other health boards face. What role has the board had in managing localised outbreaks of Covid-19, including track and trace? Professor Robertson, as the chair of the board, you can start—if you want to bring in a colleague, please do so.

Professor Boyd Robertson (NHS Highland): Madainn mhath—good morning. I will shortly bring in my colleague Pam Dudek, who is the new chief executive.

As you can imagine, we have had a very challenging and demanding year in dealing with Covid, over and above all the items on our transformation agenda. I think that we have coped very well with the Covid pandemic. We put in place a gold, silver and bronze command structure early in the pandemic—on which Pam Dudek will elaborate—and, operationally, that has enabled us to handle the challenges effectively.

We have had outbreaks. As the committee will be aware, there was an outbreak at Home Farm care home in Portree early in the pandemic, in May last year, which was a difficult and traumatic experience for the community in Skye. More recently, we have had outbreaks in care homes in Easter Ross. The board has responded to those outbreaks with increased activity through meetings. We have instituted chairs' meetings, and I, as the chair, meet weekly with my vice-chair, the chief executive officer and the deputy CEO to keep on top of what is happening. In addition, the operational arm has daily huddles.

I hand over to Pam Dudek to elaborate on that.

Pam Dudek (NHS Highland): As members may know, I joined NHS Highland, as the deputy chief executive, in April last year, when the board was in the middle of establishing its response. The gold, silver and bronze command structure, which is a standard way of working in an incident management context, was already well developed at that point. We have continued to use that structure, flexing it in accordance with where we are on the Covid journey.

I will ask Tim Allison to give a bit more detail about how we have managed outbreaks and what we have seen. To sum up, we have had strong surveillance, through the data that is available to us on a regular basis—[*Inaudible*.]—to manage the information that we have. We have worked collaboratively with those involved wherever there has been an outbreak, and we have tried to ensure that our communication is good, although that is always an area of contention for most people.

We have, like other boards, stood up in the way that the committee would expect. It is unusual to use gold, silver and bronze command in a sustained incident such as the pandemic, so we have had to learn how to do that.

Tim Allison can talk about outbreak management.

The Convener: I ask Tim, while he has the floor, to give us an indication of the board's plans in the event of further outbreaks of Covid.

Dr Tim Allison (NHS Highland): Like Pam Dudek, I joined the organisation in the middle of the pandemic, at the start of July. I have seen good and efficient handling of outbreaks and cases. We have been fortunate in having, for most of the time, relatively lower rates of Covid across NHS Highland in comparison with the rest of Scotland. However, as the chair mentioned, we have had some serious outbreaks in care homes in particular.

You asked about our track and trace procedures. Those have worked well, which has been helped by the lower level of cases. On occasion, we have needed to—[*Inaudible*.]—health boards and nationally, and on other occasions, we have been able to offer mutual aid. In comparison with many other places, we have been able to maintain telephone contact for longer with the contacts of cases, not just the index cases. We have not been able to do that all the time, and the system is not currently running as a result of the high number of cases following on

from Christmas. However, it has given us a much better idea about the nature of cases, and it has allowed us to get to the bottom of the contacts and do a little bit of back tracing to get an overall view of where Covid is across NHS Highland and what has caused the outbreaks.

On future control, we have recruited further test and trace staff on fixed-term contracts. We have also worked with the Scottish Government, local authorities, the Scottish Fire and Rescue Service and others to develop our testing processes so that testing is easier to access across NHS Highland. In addition, we have put into practice the lessons that we have learned from previous outbreaks, so that our information systems, our control and the way in which we manage are more efficient.

The Convener: My next question is perhaps also for Tim Allison. Can you provide an update on the roll-out of the vaccination programme in the Highland area, and tell us whether the board has had any on-going issues with the programme?

Dr Allison: Our progress has been good so far. NHS Highland operates a somewhat different immunisation process from that in most health boards, as we rely more on general practice than on a centralised immunisation service. That means that we are better able to serve the wider geography across Highland and Argyll and Bute, particularly in islands with lower population density and more remote areas.

In starting the programme, our priorities for vaccination have been in line with those of the Scottish Government and the Joint Committee on Vaccination and Immunisation: care home residents, care home staff, national health service and social care patient-facing staff, and the over-80s. Because we have a general-practitioner focused community vaccination service, it sometimes does not quite fit with some of the systems. Most of the data are recorded on a centralised system nationally, but it is taking a bit of time for the GP data to get through to that.

Our latest estimate for vaccinations across the whole of NHS Highland is around 18,000; we reckon that we have reached about one third of the over-80s. In two out of our three localities, we have vaccinated or offered vaccination to all care home residents and staff, and we are well through the patient-facing staff.

Some GPs have pretty well completed their vaccination of over-80s, whereas other GPs are still getting the vaccine, but we anticipate that we will have vaccinated all those in the initial cohort by the first week in February. Although progress has been variable across the region, I believe that we are making good progress overall.

Donald Cameron (Highlands and Islands) (Con): Good morning. On vaccination, are you able to give us any sense of percentages in relation to residents in care homes? Can you reassure us that GP practices in rural parts of the NHS Highland region will get the vaccine on time? There have been some reports of delays in getting it out to very rural areas.

Dr Allison: With regard to our three localities, all care homes in Argyll and Bute and in our north and west locality have been vaccinated, and we are working to vaccinate all care homes in our south and mid locality by the end of this week.

At present, there are outbreaks of Covid in three of our care homes. Although we have been able to carry out some vaccinations in those care homes, we cannot comprehensively vaccinate residents because that is not advisable or feasible in the middle of an outbreak. We will complete the vaccination there as soon as we can. Although I cannot give precise percentages, care home vaccination is at 100 per cent in two out of three localities, and in the other locality it should be 100 per cent of what is feasible by the end of the week.

You are correct to highlight that there have been some delays in getting the vaccine out to rural areas. We are using a mixed model with the two vaccines—the Pfizer vaccine and the AstraZeneca vaccine—in primary care and general practice to ensure that we maximise the speed and efficiency of vaccination.

As members will be aware, the Pfizer vaccine is harder to transport; it is not impossible to get it to remote areas, but it is more of a challenge. The AstraZeneca vaccine is delivered in most cases by a company that regularly transports pharmaceuticals—in general, pretty much all pharmaceuticals—to practices. For some practices, there have been delays of a couple of days in getting that vaccine. We are working with practices to minimise any difficulties that are caused by delays and, as I said earlier, we still anticipate that the comprehensive first phase will be completed by 5 or 6 February.

Pam Dudek: I can add a couple of comments. Last week, we asked for flexibility in relation to how we deal with our islands and very remote and rural areas. We asked whether we could take a bundle approach so that we could deliver the vaccination programme more efficiently and effectively and ensure that smaller communities are protected—for example, it is obviously tricky to evacuate patients from islands. We have had confirmation that that flexibility will be in place to support us; we now need simply to set out what we will do in each scenario so that there is national sight of that.

09:45

Secondly, on mobilising the vaccination programme, I want to make the committee aware that, over the past week to 10 days, we have worked closely with Highland Council and Argyll and Bute Council to understand how they can support us in the delivery of the programme. Both councils have been excellent in responding by supplying us with people to co-ordinate where we might deliver the vaccines; offering us domestic staff to do the cleaning; and providing stewardship by working with communities to support the effort to get people to their vaccinations. That gives us a robust backdrop for what we need our clinicians to do and what other agencies can do to support us in order that delivery is successful. There is significant partnership working, and we are looking to provide joint comms so that our messaging is clear. The relationship has been very positive, which gives us confidence in what we are doing.

We feel fairly confident about delivering vaccines to people in wave 1, and about where we expect to be by 6 February. We have done local modelling and we know what our numbers are. When we break up the numbers across general practice, we see that the figure is much more manageable.

Sandra White (Glasgow Kelvin) (SNP): The convener's opening question was about on-going challenges, and Home Farm care home on Skye was mentioned. HC-One, the private care provider involved, was bought by the Scottish Government for just £900,000. Will that have a knock-on effect on brokerage and costs for NHS Highland?

The Convener: That is a question about the financial implications of the situation at Home Farm care home.

David Garden (NHS Highland): The cost of our running Home Farm is a fair bit more expensive than it would be if we purchased the activity from the independent sector. It costs us £1.3 million per annum more to run the care home, primarily because of paying higher wages and on-costs, such as pension costs and so on. The Government has provided additional funding up to 31 March to help us to get over that hump of additional costs, and the issue will form part of our planning and discussions for next year.

The Convener: That is helpful.

A wider issue that is bound to arise in NHS Highland, as it will elsewhere, is the indirect impact of lockdown and the focus on Covid. I direct this question to Boyd Robertson in the first instance. What indirect health impacts are you most concerned about, and what action is being taken to mitigate such harms?

Professor Robertson: There is obviously an impact on our staff—[*Inaudible*.]—resilience of staff in the most difficult circumstances. We have national initiatives relating to wellbeing, and we have also put in place a number of local initiatives to cater for that. Every week, we send out to all members of staff a newsletter that offers various types of advice. We also have an employee assistance programme, which is open 24/7 to all employees, and community resilience facilities. As Pam Dudek mentioned, we have very good co-operation and collaboration with councils in running community centres. For instance—[*Inaudible*.]—a very active community response to Covid, which has helped—[*Inaudible*.].

I will bring in Pam Dudek to elaborate on those services.

Pam Dudek: I will start with the staff impacts. As Boyd Robertson said, we have a number of formal ways in which we can offer support to staff. We have wellbeing Wednesdays, when lots of tips and advice go out to staff. Some simpler daily things that make a difference, according to the feedback that I have had, are around being recognised, thanked and supported—we are straying into the culture aspect here. Simple things such as coffee, tea and break areas have also been significant. We have absolutely emphasised with the leads in our system that they need to ensure that those things are happening and in place and that we are acknowledging the work that is being done. That is in the staffing context.

The other indirect health impacts that I think are of greatest concern to everybody, given the conversations that I have had, are the impacts on people's mental health from isolation and drug and alcohol use. Some communities are seeing the really severe end of that and its impact on families, with loss of life through drug overdose or suicide, as well as general anxiety, stress and distress. We are looking very hard at how we work with our partners and communities to support initiatives that can help to address that.

I now meet regularly with the chiefs or commanders of the police, the Scottish Fire and Rescue Service and the Scottish Ambulance Service, and the Highland Council chief executive and we are going to do something similar with Argyll and Bute. It is about us making a collective effort with communities and local elected members to see how we can make progress on that. We have a bit of an initiative going on, particularly in the Caithness area, and we will look at how that methodology works and whether we can take it across other areas in a more concerted effort. We are looking to reshape how we respond to those kinds of issues. They do not always require to be medicalised; sometimes it is about a social

response. We are trying to work with people to get that right response.

The Convener: We move to questions on wider financial sustainability.

David Stewart (Highlands and Islands) (Lab): Good morning. Committee members will know that NHS Highland is my home board. I want to thank the board for its regular contact and the information sharing that it has carried out during the Covid crisis.

My first question is on whether the board will achieve financial balance in 2021-22, bearing in mind what the Auditor General said in this context:

"I consider these forecasts to be unrealistic given NHS Highland's poor performance in identifying and achieving savings in recent years."

Professor Robertson: I think that that comment was made in the context of the 2018-19 auditor's report. In 2019-20, we achieved our £28 million planned savings target. In fact, we exceeded it and had reduced brokerage from the Government because of that quite remarkable performance, which outstripped that of any other board in the country. We are well on track to achieving the financial turnaround that we need to be de-escalated from level 4, which is one of my aspirations in this role.

In the current year, we were again on track to deliver our savings target, which was around £24 million. Covid intervened, and all sorts of cost consequentials have arisen from Covid. David Garden can elaborate on what I have said.

David Garden: Mr Stewart is absolutely correct that the point that was made by the Auditor General at that time was about a lack of confidence in our ability to reach a financial balance in 2021-22. However, the context of that was our 2018-19 annual accounts. Members will be aware that a Government-led support team, helped by PWC, was brought in at around the time that the Auditor General made those comments.

The changes that have been put in place in NHS Highland have been transformational. They have allowed us to identify cost savings and improvements across the whole system. Those are transparent and robust and have been tested. As Boyd Robertson said, we delivered around £28.4 million of savings in 2019-20. A significant proportion of those—almost 70 per cent—were recurrent. That has been unusual in the NHS in recent years: most boards make savings that are non-recurrent, and which increase their underlying deficits.

We were making good progress as we came into this financial year. In February last year we were on course to develop our plans for this year but then Covid happened and we had to stand down much of our cost improvement programme for last spring and summer. We have picked that back up: we are on target to deliver around £20 million of savings in the current financial year, despite Covid. We continue to apply the robust systems that we had put in place.

The question whether we will break even in 2021-22 is a good one. I cannot answer that now. Until we unravel the impact of Covid and know what our services will look like next year I cannot say whether we are still on target to deliver that aspiration.

David Stewart: I will ask the question in a slightly different way. What level of financial support, otherwise known as brokerage, will be required from the Scottish Government on recurring and non-recurring bases? Is the board sustainable without brokerage from the Scottish Government?

David Garden: We are expecting £8.8 million of financial brokerage in the current year. That was part of the plan that we had at this time last year and we hope to deliver that, subject to some Covid funding that we expect to be announced in the coming weeks.

We are not expecting or planning for recurrent brokerage. That does not really exist. Brokerage is a temporary arrangement to allow us to meet our targets while we transform and reduce our cost base.

We expect £8.8 million in the current year. We were hoping to require no brokerage next year. I now expect that we will require some, but I am not able to ascertain the level at the moment. We still feel that we are in a position to deliver a sustainable financial balance in time, but Covid has delayed and stretched our timescale.

David Stewart: My final question is a fundamental one for the board, and is one that I have some experience of. A recurring theme over the years has been that of chronic overspending in three areas. One is locum medical staffing, the second is drugs, and the third is social care.

One example of the first comes from an article in *The Sunday Times* in November 2018 that alleged that consultants working on a locum basis had been paid £400,000 a year. I appreciate that none of you were in your substantive posts in 2018, but you do not need to be an accountant to know that paying £400,000 for locum staff causes real problems for a budget.

Would it be fair to say that sorting out those three recurring themes would lead to financial sustainability?

David Garden: That would certainly be part of it. We have put a lot of work into reducing our locum use. We have been knocked offside by

some changes to pension taxation at United Kingdom level that meant that a number of consultants have reduced their working time and we have had to take on additional locums—[*Inaudible*.]—than we were the previous year, so we are making inroads into reducing our use of locums: we have a workstream in the cost improvement programme led by our medical directors that is looking at reducing our expenditure on locums. Sustainable recruitment is the key to that issue.

On drugs, we are not seeing such a problem with drugs in the current year. The main problems are around short supply, primarily in primary care and Covid-related prescribing. The price of simple drugs such as sertraline, which is a common antidepressant, has rocketed due to short supply. However, we are not seeing huge pressures on acute drugs. We have a workstream, led by our director of pharmacy and our medical director, to look again at that area, too.

10:00

You are right about social care—adult social care is the third area that we are looking at. Pam Dudek mentioned earlier that we are working closely with Highland Council, and we have convened a joint programme management board to look at how we might transform social care services and deliver cost improvements.

You have hit the nail on the head about the three areas in which we are having significant problems, Mr Stewart. We are taking action in each of them, to bring down the costs over time.

Pam Dudek: In a linear way, that is right—those are the three areas that we need to tackle. However, our real leadership challenge is what a modern health and social care system looks like and what shape of workforce is needed to support that.

Although we will address the immediate situation as it stands, that must be underpinned by the change that needs to happen. Integration across our health and social care system in communities is a huge part of how we address social care, and we will be looking to really step up our transformation plan around that in collaboration with Highland Council to address the deficit. We need to understand the quality, size and shape of the services that we need, and to optimise that integrated resource in order to do the right things to get good outcomes for our population.

On medical staffing, there have been lots of changes over several years to the blend of staff. That includes understanding when a doctor is absolutely needed and when we have staff in other disciplines who can be trained to a level where they can contribute to the outcomes that we are trying to deliver.

We cannot lose sight of the need for wider change. We must continue to look to the future and not just keep reinventing what we have done before, where possible.

Emma Harper (South Scotland) (SNP): I am interested to know a wee bit about Covid-19 funding. I know that, on 29 September 2020, the Cabinet Secretary for Health and Sport announced £1.1 billion in additional funding for NHS boards and health and social care partnerships to meet Covid-related costs. How much additional funding has NHS Highland received to meet Covid-related costs? Has that covered the additional costs resulting from the pandemic?

David Garden: To date, NHS Highland has received £47.4 million of additional funding in the current year. That is for a range of budget headings, and specifically covers adult social care funding, urgent care and one or two other areas.

Last Friday, we submitted an update on our estimate of Covid expenditure for the current year. We are expecting that to increase by another £20 million by the end of the year, giving a total funding amount of £67 million.

The funding includes the social care elements in the Highland health and social care partnership and the Argyll and Bute integration joint board, as well as the health service costs directly. We are planning on the basis of that funding from Government.

Emma Harper: I note that some savings have also been made because of the pandemic, notably to do with reduced spending on drugs, surgical instruments and associated supplies and travel and subsistence. I am interested in the continued anticipated savings, especially with regard to travel and subsistence. For obvious reasons to do with islands and rurality, NHS Highland has a programme that supports that, but NHS Dumfries and Galloway does not. Do you think that you will continue to have reduced spending in relation to travel and subsistence?

Pam Dudek: I absolutely hope that that will be the case, particularly with regard to our climate change obligations, as a starter for 10. Covid has transformed the way that we work. Virtual meetings are common now. We have a huge opportunity to get people off the roads and still maintain connections and do our work as best we can. We are also using the Near Me service to a greater extent. Again, that is part of a bigger change programme that involves clinicians getting used to working in that way and the public getting used to receiving care in that way, when appropriate. I absolutely hope that we will continue to see that transformation—[*Inaudible*.] That

brings in efficiency and means that we are contributing to our climate duty and are generally making it easier for our workforce to maximise the time and resource that we have and, hopefully, for the public to access services.

Emma Harper: Are you monitoring the mileage reduction due to, for example, Teams meetings? Can you correlate that with any reduction in carbon emissions?

Pam Dudek: I do not have specific details on that, but it is a good question, and that is something that we should absolutely be trying to do. Dave Garden might be able to say something about the tracking of that information at the moment, but we can certainly get back to you on that, and, if we are not doing that at the moment, we can think about how we might do it.

Emma Harper: I am interested in that information, because I represent a rural area, and the Near Me service, which is powered by Attend Anywhere, Zoom meetings and Teams meetings are all reducing the amount of time that people are spending on the roads. You do not have to give me an answer right now, but I am interested in whether you will monitor those savings and what might happen in that regard in the future. At the moment, I will continue with another line of questioning.

Can you tell us how much additional funding was given to general practices, and what services it was for? Was it for digital interventions, additional opening hours and so on?

David Garden: Are you referring to Covid funding?

Emma Harper: Yes—I mean additional Covid funding for GPs in NHS Highland. Can you tell us a bit more about what services were delivered as a result of that funding?

David Garden: I do not have details of that to hand, but I can send them to you once the meeting is over. However, I can say that funding has been given to practices to support opening on public holidays and the extension of urgent and out-of-hours care.

The Convener: It would be helpful to receive that information after the meeting.

Emma Harper: I would be interested to hear more about how we are spending the additional funding. How much has NHS Highland spent on social prescribing during the past year? The committee is interested in social prescribing and how it helps to keep people out of hospital. Does NHS Highland have a commitment to support it?

Pam Dudek: I will ask Dave Garden whether he has any figures handy. That, too, might be something on which we will have to get back to the committee. I do not have an exact figure in mind to give you in relation to the Covid period. However, as I said before, it is definitely our ambition that we be in prevention, and that we take a more focused look at what can be done and our contribution to that, as a health board.

I have been involved in that at other boards, where we were asked to consider our baseline. It sat at around 4 per cent for prevention, which could be a number of interventions. Social prescribing, for example, has a very strong place in a prevention strategy. I would need to go back and see what work NHS Highland has done on that previously, unless Dave has anything.

That is certainly another area that we should be considering more, as we get back into business as usual—which is not to say that it does not have a place in Covid measures.

David Garden: I am sorry—I do not have actual numbers. As Pam said, we engage with the matter; we have an active referral scheme, for example. We will come back to the committee with information after the meeting, if that is okay.

The Convener: That is fine.

Emma Harper: Before my final question, I note the example of pulmonary rehabilitation, which helps to keep people out of hospital for exacerbations of chronic obstructive pulmonary disease.

The respiratory care action plan is being developed right now. I know that remote pulmonary rehab is being developed. The rurality of the Highlands is like that of my patch, which is South Scotland. The third sector would help to deliver that rehab. Would NHS Highland be interested in looking at that as part of social prescribing development, to support keeping folk out of hospital for lung ill health, for instance?

Pam Dudek: On pulmonary rehab, respiratory care is one of our biggest reasons for admission and is one of the biggest areas of disease on which most health boards focus. Many years ago, I was the long-term conditions programme manager in NHS Grampian, so it is something with which I am very familiar.

As Emma Harper said, the evidence base for that delivery model is robust and absolutely involves sectors beyond the public sector. I am familiar with remote pulmonary rehab being delivered very successfully and am therefore very keen to work on that basis first. I will look further into where we are with that, locally.

Dr Allison: I will add a couple of brief points on social prescribing. It is particularly important to link it with other areas. For example, we have been doing work on active travel, which links to the reduction in car use and increased home working.

We can link social prescribing and engagement with other organisations to a wide variety of the health board's work. For example, there has been excellent work done in planning for the new hospital in Aviemore, through linking with the Cairngorms National Park Authority and local voluntary sector organisations on travel and community links. That crosses all the work of the board. Social prescribing can be seen as separate, but it needs to be embedded in much of the other work that we do.

Brian Whittle (South Scotland) (Con): Good morning. I will ask about workforce challenges at NHS Highland that have been raised on several occasions—specifically, around the continuing issue of high numbers of vacancies, which is requiring greater use of locums. In October 2020, the turnover rate was sitting at 7.7 per cent and the vacancy rate at 7.9 per cent. I know that you are working on a strategy to support attraction, recruitment and retention of staff, and to build a resilient workforce. What progress has been made to reduce staff turnover and vacancies, in terms of the board's 2021 targets?

10:15

Pam Dudek: The overarching strategy is to make NHS Highland an attractive place to work and a good experience for people. As many other boards have done, we have used a range of ways of trying to engage people to work, both in the more urban areas such as Inverness, and with a particular focus on more rural recruitment. We have been successful with the nursing team on the island of Raasay—we worked with the community to establish it. I think that the committee heard about that the last time NHS Highland gave evidence.

You also heard about our GP recruitment in Argyll and Bute and some of the islands. I suppose that the solution is about how we package things for people; we have certainly been looking at how we do that and how to attract people in that way.

I am pleased to be able to let the committee know that we have seen a significant shift in interest in posts in NHS Highland. I think that I alluded to that shift when I was at the Public Audit and Post-legislative Scrutiny Committee. We are definitely trying to understand the motivation behind that shift. I hope that it is because the NHS Highland area is seen as an attractive place to come to live and work, but it could also be because people are making different life choices in the wake of the pandemic.

We have had some very successful recruitment of consultants, too, including physicians in Caithness general hospital, orthodontists and radiologists. We recently recruited two more radiologists to add to the two that we got in the last quarter of last year. One is at Lorn and Islands district general hospital and the other is at Raigmore hospital. We have recruited anaesthetists for Caithness general and Belford hospitals. The anaesthetist at Belford is also a pain specialist, which helps us with our wider strategy on pain management.

In urology, for example, we still have a 50 per cent vacancy rate—we should have six consultants—and we are having regional discussions on that. We have filled four ear, nose and throat surgeon positions—one at Lorn and Islands and three at Raigmore—and we have recruited two paediatricians and a rheumatologist. We have been pretty successful of late—in the past six months or so—in filling posts that have traditionally been hard to recruit to.

We hope that that will continue if we keep spreading the word. Often the word of peers is as effective as anything else that we can do. The narrative about the organisation, the opportunities within it and the work-life balance seems to be important to people, as you would imagine.

I feel that we are seeing something positive, but we will monitor the vacancy rate in order to see the ultimate impact of the shift on it and on our locum spend, because it should have further impacts. The more permanent staff we have, the less the spend on agency and locum staff will be.

We have also had enormous numbers—in double figures—applying for our leadership posts. Towards the end of last year, we had up to 38 applications for one post and 50 for another at director level, and we are seeing people from across the UK and all around the world being interested in coming to work for us.

Brian Whittle: Thank you. My next question was going to be about the impact of Covid-19 on the existing workforce pressures; I wanted to ask about absenteeism through the Covid-19 pandemic.

However, I am also interested to hear your thoughts on the potential for lifestyle changes and how that might positively impact on rural areas such as the Highlands. Would you consider doing a study or monitoring to see, first, whether that is happening and, secondly, where people are moving from to join the workforce? I am interested in the two aspects of that question.

Pam Dudek: On lifestyle changes, we would look anyway at information that we have in order to understand the pattern, because we need to understand what works and how we can build on it. The fact that we now have flexible working affords us a host of opportunities. People can come up here to live in a rural area and take up a

post in which they can work more flexibly, now that we have Teams up and running and the Near Me service is working well. We can be creative with some job plans to ensure that we give people the best opportunity to do their job well and make it fit within a remote or rural setting.

Work with communities is important, because communities can thrive if we can disperse our workforce to them and contribute to the economy. There is a host of ways in which the board can make a difference. We are also working with partners on how they could strengthen the potential of apprenticeships and give hope to some of our young people.

In the last wave of the pandemic, our absence rate did not fall to the level that we expected. On average, it sits at around 5 per cent, which is slightly higher than we want it to be. We have had the challenges of people shielding and staff isolating, which will continue with the testing programme. However, we have been managing well so far; we have very resilient and committed staff. We just need to ensure that we keep them there and that we support them. The motivation and passion that I have seen are really impressive. Even when people are not 100 per cent happy and morale is low, it is not possible to cut through their passion for being at work and doing the jobs that they do.

Brian Whittle: In relation to the pressures on the workforce of Covid-19, how many, and what proportion, of NHS Highland staff have been vaccinated against Covid-19?

Pam Dudek: As of last night—Tim Allison might correct me—the number was just under 7,000. From today, we are opening the health science centre to do large-scale vaccination of our health and care staff. As long as we have the vaccine, we have the capacity to do 1,000 vaccinations a day there. Our target for staff vaccinations is in the region of 13,500; we are on track for that and are doing quite well.

There was a significant change in the approach at Hogmanay. We worked over that weekend with our planning team on some numbers and modelling so that we could hit the ground running on 4 January to readjust our plan. We have made reasonable progress on that.

The Convener: Does Tim Allison have anything else to say on that?

Dr Allison: There is not a lot more to say. We are making good progress. As well as immunising our own health and social care staff, we are inviting other community health staff, including general practitioners and dentists, to be immunised. There are challenges, but we are making good progress.

David Torrance (Kirkcaldy) (SNP): The external audit report commented that

"NHS Highland continues to experience pressures in relation to Raigmore Hospital. In 2019/20, there was a £2.4 million overspend".

Will NHS Highland overspend on Raigmore hospital and, if so, how will that be addressed?

David Garden: The overspend for Raigmore hospital in 2019-20 was £2.4 million. That was driven primarily by unexpected locum costs and some drug costs that were higher than expected.

Going into 2020-21, we reviewed historical budgets that had been set. Some areas of Raigmore hospital had been overspending for a number of years, so we recognised that we needed to review budgets in the light of current activity levels and the kind of work that was being done. We did what we called a budget rebasing exercise for Raigmore and all our services, so that we started the year with a clean slate.

Raigmore is forecasting a break-even position for the current year. It is difficult to understand exactly what is driving that, because of Covid. There is less elective activity, but there are, because of Covid, more costs than we would normally have. We are monitoring the position carefully and closely. Raigmore is very much part of our recovery programme and cost improvement scheme, and has contributed significantly to the work that we have done to return to balance in the past almost two years.

We have done a lot of work and there have been a lot of improvements. This year's position will be that we break even, but I am not entirely sure whether that is down to improved financial management or Covid. We will have had a part to play in that, I am sure.

Pam Dudek: I cannot emphasise enough the surveillance that has been done of the cost improvement plan in all sectors, including at Raigmore and through engagement by our teams, as David Garden said. Departments take the lead on what can be achieved and what is realistic in terms of change or efficiency. Clinical and managerial engagement have both been really strong.

The financial recovery board meets every week; even during Covid, we have met every week since May. We have put things on simmer, as I describe it, in order to optimise the focus of the agenda and who is at the table, so that we do not pull clinicians away from clinical work and Covid work, but we are not taking our foot off the pedal. I have not experienced such surveillance and engagement in a cost improvement plan or on the bottom line before, and I have been in the health service since 1982.

David Torrance: How will NHS Highland make the shift from acute services to increased community care, as is recommended in the recent audit report?

Pam Dudek: That is a reshaping agenda for every health and social care partnership. The shift and change that we can achieve in models of care has to happen through the integration agenda. We are looking at how our integrated teams can, with the third sector and communities, make a difference in how much can be done on a home-first basis—what is the ceiling of the quality of care that we can support at home for people across the Highlands and Argyll and Bute, and, when that is not possible, what is the requirement for hospital admission?

The committee will be aware that our level of delayed discharges is not in a good place; we are not where we want to be in the league table. therefore, there is a need for a concerted piece of work in north Highland, which is under way. There is a strong programme approach to recovering that situation.

In Argyll and Bute, the position is slightly different; the position on delayed discharges is good and its work seems to be delivering, so we are looking at what we can learn from that.

We currently have a project in Inverness that we are referring to as an enhanced community programme. It has had some additional seedcorn funding to establish what changes are needed to prevent admissions to hospital and to expedite discharge. Some changes will happen in the next couple of weeks, as part of that project. We hope and expect that they will make a difference in our delayed discharge performance in north Highland. We will need to maintain close surveillance of that.

That is all about redesign and shift. From my previous experience as the chief officer of an integration joint board, I know that we can achieve shift, but the money is a different thing. How we move from historical budgets to what they need to be to support that shift is still a challenge for most people. However, at the moment, we have around 100 delayed discharges, 60 of which are standard delays, and a number of them are in Raigmore. If we can remove those delays, we will potentially have something to work with. That is the basis on which we are trying to make the shift and change.

10:30

Professor Robertson: We have also made strategic decisions on community and acute services; for example, in the recent past we had one chief operating officer post, but we have now created two posts, one of which is dedicated to community services and the other to acute services. The chief operating officer for acute services looks after not just Raigmore hospital but the three district hospitals: the Caithness hospital, the Belford hospital in Fort William and the Lorn and Islands hospital in Oban. It is a one-hospital, four-sites approach.

The Convener: We will move on to the questions that are raised by the Sturrock report.

Donald Cameron: What improvements have been made since the publication of the Sturrock report in relation to bullying?

Pam Dudek: I will start, but I am pretty sure that the chair will want to comment on this as well.

A significant framework has been put in place to address the recommendations of the Sturrock report. We have what we call a culture oversight group that is inclusive of people who were part of bringing the issue to our attention and experts in the field of organisational development and how to take the issue forward.

The programme has a number of on-going workstreams. The journey so far has been influenced by what happened to the people who were harmed and by the need to understand the size of the issue not just in north Highland but in Argyll and Bute. For those people who were harmed, we have a healing process—as things stand, we have 200 registrants for that. As we speak, we are working through the recommendations that have been made to us by the independent panel on those cohorts of people, and we expect that to continue well into this year.

That programme allows people to get support and counselling and to discuss their experience and express their thoughts to an independent panel. People can have an apology, there is organisational learning and there can be a financial component. The healing process has been significant in trying to help people—some of whom still work for us—to move on and to accept or cope with what they have experienced.

Other improvements have been made in relation to how people can speak up confidentially and advise us on issues that they are experiencing, and the mechanism to respond promptly to that. Indeed, in many cases, the issue is closed down and concluded just by that independent and private, confidential conversation.

We have employee assistance to support people psychologically and, on a day-to-day basis, we have been trying to set the tone and to encourage an ethos of respect and support for people across the organisation. We have also had training around courageous conversations. I could go on, but Boyd Robertson will probably want to say more about the cultural aspect.

Professor Robertson: Culture change is a long-term programme of work; it is not a short-

term initiative. To bring about change in culture, we have to understand the difficulties that arose and what lay behind them. To that end, I have engaged with a whistleblowers group on a regular basis. I have also engaged with people who have been harmed, and I have heard their stories at first hand. We had a two-day workshop in Inverness, at which board members heard—at first hand and through written submissions—examples of the harm that had been wrought on certain individuals.

We also went out to our staff more widely in a series of 23 engagement sessions in 11 locations across our extensive patch. I hardly need remind you that Highland covers 41 per cent of the landmass of Scotland, so it is not easy to reach out to all areas, but we made a concerted effort to do so. As the Sturrock report had recommended, we also instituted a review of the culture in Argyll and Bute, which was done by Progressive Partnership, an independent organisation. The results of that review were broadly in line with those that the Sturrock report identified.

We have recently had further close working with the whistleblowers group, which also co-produced the Healing Process service. Our external cultural adviser—who is the chair of the culture oversight group that Pam Dudek referred to—has been leading on that piece of work with the whistleblowers, to look at the root causes of the issues that manifested in 2018. That piece of work will inform the future development of our action plan. As Pam Dudek said, the panel that is engaged in the Healing Process activities is producing reports for us on a quarterly basis and is indicating what organisational learning needs to be taken from hearings with individuals who have suffered bullying and inappropriate behaviour.

We are building up a reservoir of information about the things that went wrong in the organisation, and we are addressing those issues in the steps that Pam Dudek outlined and in other elements such as training on courageous conversations, which has already been extended to about 500 of our staff, and the Civility Saves Lives initiative. May 2021 will see the anniversary of the publication of the Sturrock report. By that time, we hope to have done a further engagement exercise with staff to gauge their response to the initiatives that we have undertaken.

Donald Cameron: Thank you for those answers. What are the current levels of bullying within NHS Highland? Have they increased as a result of extra pressures that the pandemic has caused?

Pam Dudek: The balance is between the official figures, which are based on those who have come forward and raised a grievance, and what the tone and culture is across the organisation. I will start with the formal figures. We have 23 open cases under the bullying and harassment policy as it stands, and nine of those have been open for a significant period of time—for more than nine months. Those cases tend to be fairly complex and may be multifactorial, and the push from me and from others is to conclude them as quickly as possible, because that is not a good process for people to be in.

Of the 23 open cases, we have one that is at the early resolution stage, nine that are at the investigation stage, three that are at the hearing stage and 10 that are at the appeal and review stage. Over the previous 12 months, 32 cases were raised and 17 were resolved. In five cases, no action was recommended; two cases were unable to proceed due to people leaving the organisation; five cases were resolved through early intervention and resolution, which is obviously how we would like cases to be resolved; in three cases, support, improvement and facilitation were recommended; and, in two cases, disciplinary action was recommended. I hope that that gives you a flavour of the mix.

When you are in a crisis or dealing with a common issue, the striking thing is that it tends to bring people together, and there has been some impressive collaborative working, with teams supporting each other. I will not paint too rosy a picture, though, as I am also aware that, when people are under pressure—we work in a very pressured system—you can see the worst of people. We are all human beings. It is a human system, run by humans, that is relationship based, so there will be times when things get fraught and people perhaps do not behave in the right way.

We need to get a better handle on how well we deal with that and on how well our middle management, in particular, are equipped to deal with it. I emphasise that I do not blame those in middle management; it is a very tricky and challenging job—I have done it myself—and there is a lot to balance. We have a responsibility to ensure that everybody has the confidence to deal with those situations and to keep a calm, positive and supportive environment—and, if there is not such an environment, to make sure that they know whom they can turn to for support.

It would be difficult for me to say that everything is rosy and great, because I do not think that any organisation could say that. However, we are trying to get those key messages out and to support the system to support the people who work for us in the best way possible, including by enabling them to have the right conversations when something is not quite right, instead of letting it fester or get worse.

Donald Cameron: I have two more questions. One is technical and one is about evaluation. I will ask the technical one first. I gather that there was

an issue with whether tax was payable on compensation payments and that you wrote to Her Majesty's Revenue and Customs about that. Have you heard back from HMRC about the issue?

David Garden: We have not had a response yet.

Donald Cameron: My final question is about evaluation. What system do you have in place to evaluate what progress is being made along the general lines of bullying and so on, in relation to scrutiny?

Professor Robertson: We are putting in place various metrics. The Argyll and Bute survey was done, and, as I mentioned, we intend to conduct another, wider survey of staff throughout the Highland area, including in Argyll and Bute and north Highland. We also have the data that comes through our various reporting systems, including the ones that Pam Dudek has outlined in relation to the speak-up guardian service—which is the only such service in Scotland, incidentally. Those are some of the systems.

10:45

We have had a whistleblowing champion in place for about a year. Not much has been brought to his attention—direct contact with him has been very limited. Obviously, he has not been able to get out and about much, because of Covid, but very soon he will engage with staff in Argyll and Bute in a virtual manner rather than through the preferable approach of meeting people face to face in communities.

Those are some of the ways in which we are measuring progress.

David Stewart: For the record, I make it clear to the panel that I have—[*Inaudible*.]—bullying issue for the past couple of years. The key point is this: if we can change the culture of the organisation and get bullying out of the system and make it a thing of the past, that will help with the issue to do with staff recruitment and retention, which other members have mentioned.

Pam Dudek: One of our workstreams in the culture programme board is to get a set of measures that we can look at annually or more regularly, over and above the things that we normally do, so that there can be surveillance of the issue.

The guardian service feedback and reports give us a flavour of themes that have been raised and issues that are being managed, to some extent, with people being asked about aspects of their job as opposed to being asked whether they are being bullied. We have also created a listening email service—that sounds a bit contradictory—which is another mechanism whereby people can raise issues. All those things, including the diagnostics—we have done a host of things—are giving us the key themes, which gives us confidence about the interventions that we need to make. The executive team is also trying to address our visibility through a number of different comms, including videos. We want to encourage people to speak up and to look after one another.

Professor Robertson: I agree completely with David Stewart's analysis that what we do on the culture front will be key to the organisation's future. Transforming our culture is absolutely central. Pam Dudek and I are trying to set a new tone in the organisation. I think that we have been successful, and we want to continue in that regard, in partnership with the people who were affected and who are represented in the whistleblowers group.

George Adam (Paisley) (SNP): I want to ask about risk management. I know that NHS Highland is aware that it has high risk in key areas. In a letter to this committee, the Public Audit and Post-legislative Scrutiny Committee told us about a number of very high risk areas, and one of them is very concerning, given the times that we are living in. It is the

"High number of vacancies in trained mental health nursing (including CAMHS) and psychiatric medical posts with an insufficient level of nurse graduates to meet demand".

What is the current situation in that regard?

Pam Dudek: I do not have the exact figures in front of me, but I will get them for you—they might be in one of my papers. In general, we have a challenge when it comes to vacancies in mental health, as many boards do. There is a national challenge in relation to psychiatry and mental health nursing. We are looking at what that means for us as a service.

The question relates to something that I spoke about earlier. In mental health in general, there are aspects that require specialists and aspects that require a broader response, whether that is in primary care or out in the community—a kind of social response. We are thinking about how that pathway develops for a range of people, from those who are stressed and distressed through to those who have severe and enduring mental health problems. That strategic approach is under way, under the leadership of our chief officers, for the health and social care partnerships, with which mental health services sit. The strategy is being developed with people with lived experience and it will be implemented in our communities.

As you rightly point out, CAMHS has continued to pose a significant challenge for us in relation to getting recruitment to the levels that we need. We have set up a specific focus and recovery board to address that, and a number of aspects need to be

considered. I have come from a board that had a real challenge with CAMHS four years ago regarding both the right level of funding being applied and how CAMHS fitted with a slick programme that provided families and children with quick access and meant that they were dealt with as early as possible. Having had that experience, and given my connections with that board, I have linked up our leads and our programme board with that learning journey, so we can perhaps adopt some of those strategies and make a difference.

I have spoken to representatives of Highland Council and the HSCP in Argyll and Bute, and the other important aspect of CAMHS for us is the link-up with early intervention. In most CAMHS areas where there is not a well-established early intervention pathway—going through to severe issues—people naturally find themselves on a waiting list for CAMHS when an early intervention could perhaps have prevented that.

We have the right discussions in place and we have a programme board that is led by the right people—the professionals. We will be working with them and using our service to try to redefine things in a way that works for us in the Highlands, noting our remote and rural nature and using remote means to contact individuals and their families. We have quite a lot of work to do and we are absolutely not where we would want to be, but we have a plan to take things forward and make significant improvements.

George Adam: What are the timescales for sorting things out under your strategies? Do you have a plan whereby you will know where and when you have made some movement forward?

Pam Dudek: I try to approach such things, particularly when they are not good, by asking what here-and-now response we can put in place so that we can stabilise things, do a good bit of strategic planning and move the service forward for the future. We have taken some here-and-now decisions on recruitment, allowing permanent recruitment to posts that would traditionally be fixed term, so that teams can get a bit of stability, optimising the use of Near Me technology where that is appropriate.

As for a longer-term strategy, I will be looking for some clear trajectories and movement over the next three to six months, and we are probably looking at the same timescale for writing a strategic plan for mental health.

The Convener: We will move on to the subject of remobilisation.

Sandra White: Good morning, everyone. I thank all those in the health service—in the Highlands and elsewhere—for the great work that they are carrying out during the Covid pandemic. I have three questions. First, which areas have been most heavily impacted by Covid-19 and what impact does it continue to have on service capacity?

Pam Dudek: It is hard to pull out any individual area that has not been affected, but it would be remiss of us not to acknowledge the impact on elective care. We had to step down elective care significantly during wave 1, and at Raigmore in the past two weeks we had to pull it back to urgent cases and move away from routine electives. We hope that that will be for the short term only, but it has had an impact.

In wave 1, there was a significant impact on how we were performing versus where we were before Covid—and, of course, we were not in the best place on some of those markers anyway, such as CAMHS. That was an issue for us.

After the first wave, we did quite well on remobilising those services through our plan and a weekly surveillance of whether we were on plan for the targets that we had set around an assumption of getting to 60 per cent, then 80 per cent, then heading for 100 per cent of pre-Covid performance. That worked quite well, but it is obviously very concerning that we will have another knock-on effect, so to speak, from the decisions that we have had to take. We will have to monitor that really closely.

We made a good recovery in many areas. For example, we had a backlog of 600 people in endoscopy, but we are now seeing everybody within the 14-day window. That is good progress. However, it is no consolation to people in orthopaedics—if we think about why we are all here—who are waiting for hip replacements or who have musculoskeletal pain. Orthopaedics was an issue for us previously and it continues to be an issue.

Urology and the sub-specialties of bladder and prostatectomy continue to be an issue for us in our cancer care, but plans are being initiated with NHS Grampian on Dr Gray's hospital, and work is under way on a one-stop centre for diagnosis through to treatment. That will give us further diagnostic capability. The work on that centre has commenced and we look to move forward with it into the new financial year. That is a big area of impact and we are absolutely focused on it. We look at it every week in order to ensure that we understand what is happening so that we can pick it up more quickly. We have also done quite well on out-patients.

However, we also have to think about the wider system of health and social care out in the community in relation to impact and demand. Health and social care and community services never really stepped down. People still had to get

their care at home, and care homes had to continue in really challenging situations, as did our community hospitals, general practices, optometrists and pharmacies. Pharmacies got busier. All our community health and social care teams have been impacted by the level of demand and the complexity that they have had to deal with.

Nowhere is untouched. Patients who are waiting for elective surgery will certainly have seen the effect. Families who have people with learning disabilities or mental health problems will perhaps have had support in a different way, or maybe not in the intensive way that they experienced previously. There have been lots of impacts, but we have tried to maintain connections and be creative in what we do, using virtual means to support people as well as we can.

Sandra White: Thank you for that. It is a difficult time for everyone and it can be very debilitating even for people who are not waiting for an operation.

Do you have a timescale, not necessarily for getting back to normal, but for when things such as elective surgery can start again? Have you compared the exact impacts with other health boards?

11:00

Pam Dudek: Yes. In some ways, the fact that we did not experience infection rates in wave 1 in the way that other health boards did meant that we could remobilise more quickly. We were able to achieve a reasonable recovery performance quite quickly, and our success in doing so was commented on at national level. The same will apply this time. We will review the situation weekly in order to keep an eye on it, and when we feel able to re-establish our routine care and step up those services again, we will do so.

Sandra White: There is a resurgence of Covid-19 and the situation could last into September and October this year. Is it expected that the resurgence will impact on the remobilisation plan? If so, what will be the impact?

Pam Dudek: Work on our revised remobilisation plan or our annual operational plan—whatever we want to refer to it as; they are now one and the same—is under way so that we can set out our 2021-22 plan. The work will be done on the basis of our having to live with Covid, but we will try to do the best that we can in the hope that the restrictions will be effective and we can do a lot of the work that we need to do. We expect the plan to set that out clearly.

Through the work on the remobilisation plan that we did back in August, we have a good handle on where services are at. I go back to the fact that, during this time, services have changed how they do their business and have adapted. We are much more adept at being creative in how services are delivered. We have equipped a huge number of people—although it is still not enough—with the right technology so that services can continue. In wave 1, we had to do a bit of catch-up and people had to adjust, but those adjustments have now been made. For example, mental health teams are teed up with the technology to connect in that way. Virtual groups and all sorts of things have been set up.

We know a lot more and we are probably more confident in what we are doing. We have good surveillance of what we need to do and of where our issues are, which allows us to be quite swift and agile in our decision making and to know quickly what we need to do when teams are struggling.

We have worked well with teams in the Scottish Government on the access collaborative. We have continued to be successful in attracting seed funding to make changes to our services. That reflects the confidence that there was in us to remobilise the first time and to continue to make changes.

Professor Robertson: Although we are contending with the Covid pandemic, that has not stopped other developments. As recently as last week, a renal dialysis unit opened at Broadford hospital, where I am based today. That means that patients in Wester Ross and Skye will not have to go to Inverness, which is a long journey, to endure 10-hour sessions three times a week, so they very much welcome the advent of that service. We aim to bring services closer to the people.

Sandra White: No doubt we will also see the revised plan.

My last question is about the implementation of the remobilisation plan and how it has been impacted by other issues. I note from our papers that meeting the waiting times standards will cost more than £25 million, but that there has been no discussion with the Scottish Government in that regard. That might have an impact, as might the servicing costs relating to Home Farm, which come to £1.3 million—I take it that that is an annual cost. There are other issues that cause concern, particularly in relation to Brexit, such as the pharmacy workforce, estates, procurement and service redesign. Has implementation of the remobilisation plan been impacted by any of the issues that I have mentioned?

Pam Dudek: There is always potential for such issues to have an impact. Dave Garden and others in the team might want to say more about the Brexit impact, but we are working with the Scottish Government on that and, so far, we have

managed to continue to operate and remobilise regardless. Nothing in particular has been raised in the past couple of weeks that is preventing us from remobilising.

On our capability, in some areas, as you say, a significant gap needs to be filled with regard to recovery, and that might have a cost. The challenge for us will be to work out how we meet that cost. We have been encouraged to understand the issues from a national perspective, a regional perspective and a local perspective, so we are thinking about the optimum outcome that we can achieve locally and how we can work with our partners on a regional basis to try to facilitate some of that recovery by using the expertise of multiple boards, as well as how we can use the national resources that can support us.

At the moment, we use some of the national resources that are available in the independent sector, as well as getting assistance from boards such as NHS Grampian in order to deliver against some of our targets. We will continue in that vein in order to try to be as slick as possible.

The leadership challenge will be to try to recover our position in relation to the standards that are set out in the treatment time guarantee. That will be challenging, but it is the ask. We hope that our revised reorganisation plan will give us confidence about how we will get there, what that outcome will look like and what risks we have to take account of.

Emma Harper: Obviously, a lot of work is happening in NHS Highland on Covid, vaccination and post-Sturrock organisational development issues. I am interested in how all that is being communicated to the staff and the public. Has there been feedback on how the communication has been received? It is great that all that work is being done, but it is important to ensure that that information is getting out to the people who are receptive to the changes.

Professor Robertson: You are right to point out the need for good communications internally and externally, and we have just appointed a head of communications and engagement, one of whose tasks will be to bring our comms strategy up to date.

As recently as this past week, we have had a joint communication with Highland Council, externally, about the Covid situation and our collaboration, urging people to abide by the rules, because we were concerned about the escalation in Covid numbers after Christmas. Happily, we are now seeing a diminution in those numbers.

Internally, we have various mechanisms for regular communication; Pam Dudek will talk about them in a moment. For instance, we have a weekly round-up from our communications staff to all employees. At one time, there was a feeling that staff were getting too many disparate forms of internal communication, and this was a way of bringing communications together and possibly increasing the amount of attention given to them by having them in one form of communication.

I want to go back to the Skye care home issue and the point that Ms White raised. We see the Home Farm care home in Portree being part of the redesign of services in the north of Skye. That is an on-going initiative and it again points to the fact that activity goes on as normal, despite the Covid pandemic.

Sir Lewis Ritchie has been reviewing progress on the Skye, Lochalsh and south-west Ross out-of-hours and other service provision, and he reported to us at the end of October that he was very satisfied with the progress that we were making with consultation, collaboration and co-production with the community. I see it as vital to the future health of the Highlands that we, as a board, co-produce with communities, collaborate with councils, and work together to get the best solutions for the people of the Highlands, whether they be in Lochaber, where we are also engaged in a redesign project or in Caithness, where we have another redesign project, or in Skye, or wherever throughout the area.

Communications are vital and there is work to do in that space. I will ask Pam Dudek to say a bit more about how we are addressing communications issues.

Pam Dudek: I just want to expand on what Boyd Robertson has said. We know that there is more we can do and we want to improve significantly on how we communicate and how accessible we are as a board and an executive team across all our services.

We have a number of things in place, but some other things are starting to come into being. We have the weekly round-up, but we also have what is known as the silver bulletin, which captures all the Covid information that staff will need. When it happens, we also do videos from the gold meeting so that we can round up and give people visibility of what has happened in the week, and so that we can try to get key messages out.

We therefore use a number of internal mechanisms to communicate and we sense-check that with staff all the time to see whether it works for them. As you can imagine, some people find it really useful and some do not like certain ways of communication, so we need a range that fits with the differences between people.

Joined-up communication with councils offers us a lot in terms of reaching out to communities and using some of their established mechanisms

through schools and so on to get our messages out.

We are going to trial a weekly column in one of the local papers in north Highland, and I have suggested that it might be good to try that out in Argyll and Bute. That might get us out into communities and help to make what we are doing more visible to people.

11:15

It is also important to cultivate our relationship with the press in a way that allows us to interact positively so that people can see that we are open and transparent. I also hope that our briefings for MPs, MSPs and our elected members will make a difference. We are strengthening connections and putting ourselves out there.

Tim Allison has done a huge amount of work on Covid in recent months in his role as director of public health. He has worked with councils, putting messages out to the community as well as internally. He has featured on many videos.

That will give you a flavour of what we are doing.

The Convener: There are two remaining areas in which members have questions, but time is marching on, so I will ask David Stewart and Donald Cameron each to ask a single question for the witnesses to respond to. Any further questions can be pursued after the meeting.

David Stewart: My question has been dealt with by previous answers.

Donald Cameron: How is NHS Highland ensuring that people who are isolated get the help and support that they need during the current lockdown, given the issues to do with loneliness that we all know so well?

Pam Dudek: I will talk about both staff and the general public.

We know who our staff are and we know who may be isolating. We use our line management mechanisms to stay in touch with people and to remind them of the ways in which they can get in touch, should they feel the need for further support or if they are distressed or struggling.

On working practice and home working, we have been clear that although, obviously, we want people to work at home, a risk assessment has to be done to ensure that that is okay for them. In some circumstances, safe working practice requires that we allow people to come to work. Home working is not a good thing for everyone. From a staff perspective, it is quite straightforward.

From a community perspective, we rely on those who are already in touch with us and our services, including primary and community care. We know who they are and local GP practices, particularly in rural areas, know who might be vulnerable. We reach out to them or at least connect them with other support in the community or virtually.

For the people whom we do not know, we must encourage them to seek help. We may need to have stronger messages about that. The community planning response to that is important. How do we partner with communities to understand that? Communities have already responded to the pandemic. They have looked after their own people and communities. There is local support and we have been trying to link in with that.

The Convener: I thank Boyd Robertson and all his colleagues who have given evidence in this comprehensive session. There are some areas where witnesses have offered to come back to us with further information or to provide numbers. We look forward to receiving those in due course and we will write to the witnesses about that after the meeting. We have explored the issues thoroughly, but if we have any further questions, we will write promptly to the witnesses.

Thank you again for your evidence and your comprehensive answers. We will consider our next steps accordingly.

Provisional Common Framework on Food and Feed Safety and Hygiene

11:19

The Convener: Agenda item 2 is consideration of a provisional United Kingdom common framework on food and feed safety and hygiene. Common frameworks are being developed to ensure that rules and regulations in certain policy areas remain consistent across the UK following exit from the European Union. Our role is to scrutinise the common frameworks that fall within the committee's remit. We have a role to influence the content of such frameworks and to monitor their application, and to act as a conduit between stakeholders and the Scottish Government.

The committee has received a letter from the Scottish Government sharing the provisional UK common framework on food and feed safety and hygiene, and requesting that we provide our commentary on it. In order to do so, we are today taking evidence from stakeholders, and next week we will hear directly from the Minister for Public Health, Sport and Wellbeing.

For today, I once again welcome to the committee Professor Paul Haggarty, the deputy director of the Rowett institute of nutrition and health at the University of Aberdeen, who is representing SEFARI, the Scottish Environment, Food and Agriculture Research Institutes; and David Thomson, chief executive officer of the Food and Drink Federation Scotland. Thank you for joining us. We very much appreciated your input to our previous consideration of another common framework, and we value your evidence in relation to this one.

I will start with the written evidence that Paul Haggarty provided on the framework. If David Thomson wishes to come in, he should simply indicate by typing R in the chat box. Likewise, if Paul Haggarty would like to answer a question that is put to David Thomson, he should draw my attention to that with an R in the chat box.

Paul Haggarty mentioned a range of organisations that should be involved in developing the framework. Have either of our witnesses been asked directly to contribute directly to the development of this particular framework, following your evidence on the other one?

Professor Paul Haggarty (Scottish Environment, Food and Agriculture Research Institutes): I can confirm that I have not been involved in the consultation.

David Thomson (Food and Drink Federation Scotland): I first apologise for not providing a written contribution on the framework. Unfortunately, we have been a little pressed over the past few weeks, as you will imagine.

We were involved in the framework in some way, as we were with the framework that we talked about previously. We were invited to a stakeholder day on 9 October and had some additional information provided to us. That was a UK-wide stakeholder day that was run by Food Standards Scotland and the Food Standards Agency. Prior to that, as I think was set out in the minister's letter, the framework has been discussed in the Food Standards Scotland board meetings over the course of the past few years. Our ability to contribute has obviously been limited because, even on 9 October, we were talking about a previous version of the common framework.

When we were at the committee previously, we discussed at length our concerns about the interaction of the common framework and the then United Kingdom Internal Market Bill. Obviously, we have not had much opportunity to discuss the issue with our members. Even at the stakeholder day, there was limited time to provide contributions.

We have been involved and we were part of a stakeholder day, but we have not been heavily involved.

The Convener: In that respect, we seem to be in a similar place to the one that we are in with the other framework that we discussed: some people are engaged and others are not.

Paul Haggarty's written evidence states:

"mechanisms in relation to food and feed safety regulation, enforcement, etc, have developed organically over decades. They work well but they are enormously complicated. It is possible that the UK may fail to maintain those standards inadvertently by failing to appreciate the full complexity of the process."

Will you comment on that and suggest how such an inadvertent failure may be avoided?

Professor Haggarty: The whole regulatory framework is extremely complicated. It covers dietary requirements, novel foods, food safety, toxicology and so on. All of those fields have an input into the decisions about foods. It is a case of multiple jeopardy, if you like, because a particular feed or foodstuff has to meet all the requirements.

The current set-up is very complicated; the information flows cover different countries and committees within them. The framework provides a pretty good summary of the situation. Having worked within the system to some extent through scientific advisory committees on nutrition, novel

foods and toxicology, I can see from that perspective how complicated it is. With a document such as the one that is before us, which is not able to fully summarise all the linkages, it is not possible to say whether the situation is fully covered.

I have one suggestion regarding consultation. A large number of groups have been consulted, but it might be worth involving the EU, through the European Food Safety Authority, in the consultation to see whether it considers that anything has been missed. That would be extremely helpful. Some of the committee members on those panels are—even now—from the UK.

The Convener: That is an interesting suggestion.

Before I bring in David Thomson on the same question, I want to check something with Professor Haggarty regarding his answer to the first question about not being involved in the framework. I know that today, as well as speaking in your capacity at the Rowett, you are speaking in relation to food and agriculture research institutes across Scotland. Would it be true to say that neither you nor your colleagues in those institutes have been consulted on the food and feed safety and hygiene framework?

Professor Haggarty: We at the Rowett institute have not. As far as I am aware, institutes within the SEFARI network have not been directly consulted on it either. They may have had invitations to the open sessions that FSS helpfully arranged, but I am not aware of any formal requests.

David Thomson: I would underscore what Professor Haggarty has just said. This is a very complicated area of regulation and it covers a lot of different types of issues. It underpins the production, distribution and sale of food and drink and feed across the UK. It is important, therefore, that we have a common framework that allows for processes to be as smooth as possible for businesses. However, as Professor Haggarty said, it is currently difficult to judge whether the framework covers everything. I agree with his suggestion on consulting the European Union institutions and those who are involved in the area, not least to learn where elements of the framework could be better.

Brian Whittle: Professor Haggarty, you state in written evidence that you do not feel that the common framework is fit for purpose, and that it

"describes the overall system well but there are fundamental logical inconsistencies at the heart of the proposed arrangements that will undermine the implementation".

Can you expand on those concerns and say why you believe that the framework is not fit for purpose and what may need to change?

11:30

Professor Haggarty: First, I have to say that the FSA and the FSS were in an unenviable position. This is a really complicated area, and they have done as much as they can to address concerns and produce something that is as simple as possible.

My concern is around the Northern Ireland question. It is pretty clear in the framework that Northern Ireland has to stick with the current EU framework, which is not static but changes almost daily. A big volume of regulatory considerations go through Europe, so it is a constantly moving situation. Currently, there is alignment between the rest of the UK and Northern Ireland, but if Northern Ireland has to continue with the European position, we are basically going to have the four nations at the table with Northern Ireland essentially representing the EU in discussions about how to deal with regulation. It is very difficult to see how that could operate in practice and be consistent with the aspiration to maintain consistency across the UK.

I am sure that there will be some minor changes that it will be possible to accommodate, but I imagine that issues will come up within a reasonably short time. There may be disagreements between the UK and the EU in relation to how they want to proceed, which would put Northern Ireland in a very difficult position.

David Thomson: On the Northern Ireland issue, we agree with Professor Haggarty. Although the framework sets out how it will work, it is unclear how it will work in the context of the EU's risk analysis procedures for food and feed.

Another issue is that when people seek licences to put new and novel foods on the market, they will need to go through two processes: one for Great Britain and one for Northern Ireland. That might make the UK market less attractive to businesses that want to innovate.

Emma Harper: I am interested in the framework's impact on internal trade and exports. My question is perhaps for David Thomson, but have either of you had an opportunity to consider how the UK and EU trade arrangement might influence the operability of the framework with regard to exports from Great Britain to Northern Ireland and markets in the European Union?

Professor Haggarty talked about Northern Ireland, but the paper that we have in front of us mentions risk management decisions that are currently taken at a national level in areas where

EU legislation permits different approaches, such as raw drinking milk. I will give an example from my local area. There is a factory near Newton Stewart that processes milk and yoghurt, including protein-based yoghurt, and its products go back and forward to Northern Ireland, and then from Northern Ireland to the Republic of Ireland. Are you concerned that there might be conflicts in such cases with regard to the operability of the framework?

David Thomson: It is a very complicated picture, as you have set out, and its interaction with the current terms of the EU and UK trade deal is probably still to be seen. We know that some issues have already been caused with trade between the UK and Northern Ireland and the Republic of Ireland because of the current set of legislation and the terms of the trade deal. Trying to divorce those is quite difficult at the moment.

The UK needs to be able to prove that its food is safe and that it matches the level that is required for export into Europe, so we need to have a strong and robust system that allows us to do that. I hope that the common framework facility is that system. If someone is exporting into Europe, they will need to match the European legislation in any case, and that will quite often need to be validated in the UK by the UK's health system and food safety system. It is highly likely, in particular as legislation develops and there are differences between UK legislation and European legislation, that the EU will require more stringent assurances.

There is not necessarily any initial impact that we can divorce here from the current ructions about the trade deal, but as legislation begins to differentiate itself in Great Britain, it may become an issue. However, the bottom line for any company exporting to Europe is that it needs to match the European legislation; the key issue is how that is validated country to country.

Emma Harper: As you highlighted, it is a complex issue. I have concerns about food and feed safety, as we begin trade deals and as other produce comes into the country. How are we going to monitor all the regulatory processes? It is an issue that I have raised previously. We will have to look at what is happening in the EU, and look in detail at all the regulatory mechanisms in the framework. Professor Haggarty, do we have the ability to monitor the framework? How can we do that in a timely and realistic way? Who should be monitoring the process as it moves forward?

Professor Haggarty: The UK definitely has the scientific expertise to do that kind of work. The UK already makes a major contribution to EU considerations in that area, so such an approach is definitely possible. However, it is extremely difficult to do, and I would imagine that a team of people—I do not know how big—would have to operate at an administrative level and monitor all the regulation in real time as it changes in Europe. Such a team would either have to put in place a dissemination mechanism to let producers and consumers know about those changes and how to cope with them, or introduce them into UK law reasonably quickly. Because of the sheer volume of regulation and the rate of change in Europe, I imagine that there would have to be constant monitoring.

Emma Harper: Looking at the intensive processes and complexity involved in constant monitoring, do you have concerns about the interoperability of the framework? You mentioned Northern Ireland. Will there be continued challenges in how the UK makes the common framework work with Northern Ireland?

Professor Haggarty: The Northern Ireland situation is very complicated, for the reasons that I set out. Basically, Northern Ireland will be following the European situation. Actually, there may be an opportunity there. As regulations come out of Europe and are taken up in Northern Ireland, there could be a communication link to the rest of the UK to say, "This regulation is changing. You're aware of it now and you can decide whether to go with it or disengage from it."

The Convener: Brian Whittle has a supplementary to his earlier question.

Brian Whittle: My question concerns what needs to change. The committee will be developing recommendations. From your perspective, what changes are needed around the operability of the framework to make it more palatable?

Professor Haggarty: The Northern Ireland situation is just a logical problem. There are two aspirations that are to some extent incompatible—the desire to hold to Northern Ireland within a UK context and the fact that Northern Ireland also has to work with the European legislation. To be honest, I do not know how to fix that problem. David Thomson will know more about this than me, but there could be many advantages to maintaining a similar regulatory framework to Europe's, certainly in terms of export and import. The extent to which the two regulatory systems track each other is the extent to which the framework will be successful.

David Torrance: How will what is now the United Kingdom Internal Market Act 2020 impact on how the framework operates?

David Thomson: I was anticipating that question. The 2020 act now sets out a way for common frameworks to be incorporated. That is new since the previous time we spoke, when the act was just a bill. It is an interesting development, and it means that this common framework could

potentially be exempt from the terms of the 2020 act, although there is no agreement on that.

As we have already discussed at length, this is a very complex set of regulations that covers a vast range of issues in food and feed. It may be that the common framework will be exempt from the 2020 act's principles, or you may end up with a set of issues in relation to which each Government is looking at the situation and coming up with different solutions. However, that is not the point of the common framework or the 2020 act, so I hope that the act's new provision makes it much clearer how the common frameworks integrate and, therefore, how this particular common framework will work.

David Stewart: I have a question about pre-market approvals and re-authorisations, on which I have looked at the answer from the minister on 30 November. Are you reassured that the processes for businesses to apply for pre-market approvals and re-authorisations for both the GB market—for novel foods, for example—and the Northern Ireland market are clear enough and in place right now?

David Thomson: As I mentioned earlier, we are concerned, but it is an inevitability of the Northern Ireland protocol that there is a different set of pre-market access issues and procedures for Northern Ireland from those for the rest of the UK. Other than that, as far as we understand it, they mirror the European processes. From our perspective, that seems to be okay at the moment. However, the danger of separating off the Northern Ireland market from the GB market and making the UK system more complicated is that people might not apply for that kind of thing within the UK, and, therefore, we might lose some of the food innovation that we are rightly known for.

11:45

Donald Cameron: This question is for Professor Haggarty. In your written evidence, you state that the framework generally demonstrates

"an understanding of the overall competencies that will have to be taken on by the UK"

but that

"these are mostly presented as lists and it is"

unclear

"whether the complex nature of the linkages between these processes has been fully appreciated."

Will you expand on the risks that that approach may present, please?

Professor Haggarty: The information that is in the framework is as good as it can be. The problem is that representing the system fully would require a fairly substantial document with diagrams showing the interactions between various processes. For example, the Scientific Advisory Committee on Nutrition—SACN—is represented on the Advisory Committee on Novel Foods and Processes. SACN has also access to the Committee on Toxicity of Chemicals in Food, Consumer Products and the Environment, and so on. When SACN is dealing with particular issues, it can call on—dynamically, if you like—lots of different processes and expertise. It may be that the FSA and FSS have fully appreciated that in how they have looked at things, but the documentation is not detailed enough for us to be able to say whether that is fully the case.

Sandra White: I want to ask a particular question, and possibly a follow-up question, on the dispute resolution mechanism. Some interesting comments have come out of the House of Lords Common Frameworks Scrutiny Committee. I was struck by a written response to that committee from the FSA, which stated:

"The Framework dispute resolution process is not triggered automatically: it can only be triggered where either officials or Ministers (in any nation of the UK) wish to object to the approaches recommended in one or more of the Great Britain nations."

The UK Government is undertaking a consultation on the use of gene editing to modify livestock and food crops in England, and it has authorised the use on sugar beet of a pesticide that kills bees and is banned in the European Union. How would the framework dispute resolution process work in such cases, including in relation to genetically modified crops, which are banned in Scotland?

You mentioned EFSA. The EU has the most stringent regulations in the world. Everything is subject to extensive evidence-based science, case by case. How would the dispute resolution process work in Scotland or Wales, or even in Northern Ireland, which is still under EU regulation?

Professor Haggarty: That is a very good question, so I guess that it deserves a very good answer. If there are changes to the regulations on genetically modified organisms, nicotinamide pesticides and so on, the UK committees, which have already largely agreed—or have agreed—with the European position, would have to look again at those areas.

On the concept of triggering an issue, I do not know what the monitoring arrangements are. Obviously, ministers or officials can trigger the process. I guess that it would be up to them to monitor the decisions that come out of the committees.

The kind of things that you have talked about are probably related to risk management rather than risk assessment, because they are about the

interpretation of evidence and societal choices. One of the difficulties with the dispute resolution process is that the framework emphasises the consideration of objective evidence but it is hard to base societal issues and value judgments on that kind of evidence. In reading through the documentation, I was less relaxed about whether the resolution mechanism would work in all cases. I do not know whether that answers your question.

Sandra White: It gives me more questions. You answered the particular part about the interpretation of evidence and risk management, but there is no answer about the risks that such a decision going ahead would present. You commented that the committee might raise those questions with the EU and EFSA. Would that clarify the point?

Professor Haggarty: The EU and EFSA have already made decisions in those areas and will continue to do so. I guess that the UK would have the choice whether to stick with their interpretation of the scientific evidence or whether to change it.

To some extent, this is where we come across the risk assessment and risk management problem. Many of the differences between countries with regard to what they do in areas such as genetically modified organisms are to do with their interpretation of the quality of the available evidence. For example, the US considers the same evidence base as the EU and has come to the conclusion that GMOs are adequately safe for it to proceed with. Europe has currently not concluded that. The UK would be in a position to choose where to go on the matter.

David Thomson: I am really glad that Paul Haggarty answered that question first. He raised the point that the issue is really one of risk management and the decisions that politicians, Governments and civil servants make on the basis of the evidence. As Paul has said, the evidence tends to be community-accepted, scientific evidence from around the world; the question is what one does with it.

In the area of risk management, it is much harder to see an easy way out of the difficulties that the different responses to the risks create, which society, stakeholders—both in the industry and in the broader third sector—and public opinion inform. That is really the point at which risk management and dispute resolution processes will come into conflict. It is easy to see things written down and say that they make sense, but we are talking about emotive and difficult issues. We all have to see how that approach will work in any of the common frameworks.

Sandra White: I have a small question—maybe it is more of a comment—and it might be for the Scottish Government. The House of Lords Common Frameworks Scrutiny Committee's response from the FSA mentions the dispute resolution process but goes on to say that

"it can only be triggered where either officials and ministers in any nation of the UK wish to object".

It mentions "any nation", not just England, which has already said that the pesticides you mentioned, for example, can be used in England.

The question that I am asking is this: what would the Scottish Parliament be able to do, or what could the Scottish Government do, to stop that type of thing coming into our country? Wales and Northern Ireland might do the same. I find it difficult to get my head around that. I do not know whether we will get any answers.

The Convener: No, but we can ask the question. Paul Haggarty wants to come in.

Professor Haggarty: These are all scientifically based questions, so we must go back to the scientific evidence. If one country wanted to proceed with that, we would have to deal with it on two levels. First, you would have to go back to the scientific evidence, and we would say, "Let's look at this. Does everybody agree on this?" The devolved nations could take it as read because they do not have their own sub-committees to look at what central committees are doing. They have the opportunity to take it as read, and the quality of the scientific advice in the UK is very high, so it would be reasonable to accept that, although the real decision will, again, be made at the level of risk management and societal choices. However, just to add another complication, there is a particular area that you have to keep in mind with GMO in that, if one sector or one food wants to go with that, it could have an effect on other sectors and their ability to sell their products. These things can be very complicated, and I guess that there are actually three levels on which the complication operates.

The Convener: David Thomson might want to add something on that.

David Thomson: Yes, I can do that. The interesting thing from our perspective is, I am afraid to say again, how that interacts with the United Kingdom Internal Market Act 2020 and the common frameworks. This common framework covers some elements of GMO, and if that act was in place and this common framework was not exempted from it on GMO, that would mean that, although Scotland's production methods, for example, could ban GMO, the sale of GMO goods could not be banned in Scotland. However, if the common framework and the GMO element were included in the exemptions from the act, it would really depend on what was decided. You could argue that there is a position in which both the sale of GMO goods and their production could be

banned. It is not really an issue of the common framework; it is how the common framework interacts with that regulation.

The Convener: That is very helpful for the committee's understanding. Finally, I call George Adam.

George Adam: Thank you, convener. The Health and Sport Committee obviously believes that it has a role in the common frameworks and how things move forward. What further role would it be helpful to the industry and to consumers for the Parliament to perform during all this? In particular, what should the Parliament track as the framework evolves?

David Thomson: We agree that the Scottish Parliament and this committee have a fundamental role in tracking this complex area of regulation. We agree that many of these issues need more rather than less debate as we move forward, and we would welcome the opportunity to continue to contribute in this manner to support our members. The other element is the proposed creation of the office of the internal market, which will look at the United Kingdom Internal Market Act 2020 and its operation. I imagine that that must look at where there are restrictions between common frameworks and the operation of the act. That is another area where we would welcome consideration of how well the office of the internal market delivers for businesses in Scotland by this or another committee of the Scottish Parliament.

12:00

Professor Haggarty: Thank you for what is another very complicated question. I would argue that the scientific arena is pretty well covered by the FSA and FSS—they can oversee it very well. However, as we have discussed, most of the difficulties will come with risk management and societal decisions, which obviously is an area where the Parliament and your committee will perform an important role. In watching over all those things and decisions, I am absolutely sure that, within a short period, you will have some issues to consider.

The Convener: I suspect that you are right about that. No doubt, there will be further food for thought for the committee and its successor committee in dealing with all those areas.

I thank Paul Haggarty and David Thomson once again for their valuable and insightful contributions and evidence to assist the committee. No doubt, many of the questions that we have addressed to them will be addressed to the minister when we hear from her in a week's time.

12:01

Meeting continued in private until 12:37.

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