OFFICIAL REPORT
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Health, Social Care and Sport Committee

Tuesday 7 September 2021

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Tuesday 7 September 2021

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

3rd Meeting 2021, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

*Paul O'Kane (West Scotland) (Lab)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Donna Bell (Scottish Government)
Jason Leitch (Scottish Government)
Humza Yousaf (Cabinet Secretary for Health and Social Care)

CLERK TO THE COMMITTEE

Lucy Scharbert

LOCATION

Committee Room 2

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 7 September 2021

[The Convener opened the meeting at 09:31]

Decision on Taking Business in Private

The Convener (Gillian Martin): I welcome everyone to the Health, Social Care and Sport Committee's third meeting in 2021. No apologies have been received and all members are present.

Item 1 on our agenda is to decide whether to take in private item 4, which is consideration of the evidence that we hear on session 6 priorities for the Cabinet Secretary for Health and Social Care. Do members agree to do so?

Members *indicated agreement.*

Scottish Government Priorities (Health and Social Care)

The Convener: Item 2 is evidence from the Cabinet Secretary for Health and Social Care on his priorities for session 6. All our witnesses are appearing remotely this morning. I welcome the cabinet secretary, Humza Yousaf, who is joined by Caroline Lamb, director general for health and social care and chief executive of NHS Scotland; Professor Jason Leitch, national clinical director; and Donna Bell, director for mental health and social care. Good morning to you all.

My colleague Paul O'Kane has the first question for you, cabinet secretary.

Paul O'Kane (West Scotland) (Lab): I draw members' attention to my entry in the members' register of interests, as I am a councillor on East Renfrewshire Council.

As we meet this morning, we know that Covid cases have been increasing throughout the summer, and that there have been a number of very seriously concerning situations across our hospitals, with code black status being, or almost being, reached.

I would like to hear the cabinet secretary's view on the capacity that we have to deal with the current surge, and any future surge, in cases. We know that there are concerns, for example, around staffing levels and staff fatigue. I know that we will come to those issues later in the meeting, but first I want to get a sense of where we are in the pandemic now, in terms of capacity and our preparedness for the future.

The Cabinet Secretary for Health and Social Care (Humza Yousaf): I thank Mr O'Kane for the question, and I thank you, convener, for the invitation to address the committee today. I am genuinely sorry that I cannot join you in person—I hope that the committee understands. As many of you will know, after a gentle game of badminton, I seem to have ruptured my Achilles tendon, so—as Dr Sandesh Gulhane, Emma Harper and other members with clinical experience will tell you—I have to keep my leg elevated for as long as possible.

Before I answer Mr O'Kane's question in some detail, I want to say how genuinely pleased I am to be in front of the committee. From me, as the Cabinet Secretary for Health and Social Care, and from my team, you will get responsiveness, openness and transparency. We will not attempt to stifle debate or be in any way defensive with regard to the work that we are doing, nor will we try to be anything other than constructive in respect of the committee's work.

Having been a minister for the best part of nine years, I have always thought that committees and Government can work best when we focus on moving in the same direction together. I am really looking forward to working with the committee, and I am sure that we will generate more light than heat.

To go back to Mr O'Kane's question, capacity is absolutely imperative. As the committee would imagine, my immediate focus, from the minute that I was appointed as Cabinet Secretary for Health and Social Care, has been the pandemic and the current crisis that we face.

We are still in the midst of the pandemic and—as Mr O'Kane rightly says—we face some real and significant challenges. Our job is, therefore, to work with every single health board up and down the country to maximise capacity and flex in the system. We have additional capacity—we based our modelling for capacity on best-case, medium-case and worst-case scenarios, and we have ensured that there is as much flex as possible in the system.

I will be frank, however—I intend to be frank with the committee, not just at this session but in any appearance that I make—that that involves making difficult decisions. We are seeing those decisions being made up and down the country; Mr O'Kane referred to some of them. There are usually tough decisions to be taken on non-urgent, elective surgery. A number of health boards have now decided to pause such surgery, because doing that is one of the pressure valves that we have. We cannot stop people having heart attacks or strokes, so we have to—and we will—attend to that sort of urgent care. With non-urgent care, we are able to release the valve where necessary to increase the capacity in our national health service.

Of course, that does not come without consequences. I have no doubt that we will talk about backlogs and the fact that every paused surgery has an impact on the individual who is waiting for their elective procedure. There are huge challenges, which is why controlling transmission of Covid is our top priority—we do not want to overwhelm an NHS that is already under extremely significant pressure.

Paul O'Kane: I thank the cabinet secretary for that answer. On what he said about recovery of services, a number of health board areas and hospitals have made the decision to cancel operations and surgeries, and there is concern about how long it will take to recover the previous position. Professor Caroline Hiscox, in NHS Grampian, has said that it will take "years" to recover the position in which people are able to get diagnosed and treated and get the operations that they require.

As I indicated in my earlier comments, I want to move on to talk about workforce pressures. Given what we know about those pressures and the number of people who, whether they are doctors or nurses, are considering leaving the medical profession, what is the cabinet secretary's view on what could, essentially, become a perfect storm? Staffing levels are reducing, and a long period of time is required to recover to a position in which we are able to treat people in as normal a way as we would expect and that everyone in Scotland would want.

Humza Yousaf: I thank Mr O'Kane again for an important question that gets to the nub of the issue.

First, I point out that NHS staffing is at record levels—over the past year, we have increased the number of staff by 5,000 whole-time equivalents. That is not to say that there are not significant challenges. In some areas of our NHS workforce the vacancy rate is too high, so we will work to try to reduce that.

Mr O'Kane used the phrase "a perfect storm". I agree whole-heartedly with that description. The summer has seen a perfect storm, with higher rates of transmission—we have eased restrictions, so we would expect that to happen—and in the past month, schools have returned as well. Understandably, NHS staff are taking some of their annual leave because they are—again, to be frank—knackered as a result of the past 18 months. Community transmission is high, which has an impact in terms of those in the NHS having to self-isolate if they test positive or become a household contact.

That is a perfect storm, as our NHS recovers. It is not like it was at the beginning of the pandemic, when we stripped the NHS right back to urgent care, cancer treatment and so on. Now, we are recovering the NHS, so the headroom is much smaller. I could say a lot more, and the "NHS Recovery Plan 2021-2026" goes into a great deal of detail about how we will achieve those ambitious targets, including that of increasing capacity by 10 per cent over the course of the plan, which will involve the additional recruitment of staff. As Mr O'Kane alludes to, it will also require the retention of staff, and we have a good record on that. Our pay increase for NHS staff ensures that they continue to be the best paid in the United Kingdom, and it is the biggest single-year pay increase for the NHS, which I am really proud of. However, there is more that we can and will do.

The Convener: Looking at the topical issue of certification from a clinical point of view—the COVID-19 Recovery Committee might want to look at it from a different point of view—we are proposing to join quite a few other European

nations in having vaccination certificates. From that point of view and with regard to the mitigation of the impacts of Covid, what is the rationale behind certificates? You have referred to the idea of heat versus light. There is a lot of heat around the civil liberties aspect of vaccination certificates, but there has not been enough discussion about the clinical rationale behind the Government's decision.

Humza Yousaf: I will say a bit on that, and our national clinical director, Jason Leitch, might want to add to or correct what I say. There are two primary purposes to what we are doing. First and foremost, I want to say that we have been very public about the fact that we are not taking that step lightly at all, and the Deputy First Minister and the First Minister have spoken about it in a similar way. It is being done because of the challenging circumstances that we face because of the case numbers. Everybody knows that the case numbers yesterday were around 7,000, so we are in a challenging position. I would not have considered such a scheme had case numbers been far lower, as they were at the beginning of the summer. However, we are now in these different circumstances, and therefore our thinking must evolve.

There are two things to say about the clinical rationale. First, yes, we hope that vaccine certificates will help us to control transmission in particularly high-risk settings. We should remember that the certification scheme is limited to high-risk settings, such as nightclubs. Again, we can go into the reasons why we think that nightclubs are high-risk settings, but they involve a largely, although not exclusively, younger age cohort, and we know that there is lower uptake of the vaccine in that age group. We know that some of the behaviours exhibited in nightclubs, such as close-contact behaviours, are riskier with regard to transmission of the virus. Therefore, in that setting and the other settings that we propose to include in any certification scheme, we hope to be able to control transmission. From the point of view of public perception, if I were to attend the football at Parkhead, I would feel much safer knowing that everybody around me was double vaccinated too. That does not mean that these become no-risk settings—nobody is suggesting that. It just means that we can mitigate some of the risk.

The second point, which is important, is that we hope that vaccine certificates will incentivise people to get vaccinated, particularly in the cohort in which uptake is low. It is far too early to comment definitively on causation, but the figures for first dose vaccinations administered over the weekend just gone were 50 per cent higher on the Saturday and 70 per cent higher on the Sunday than on the previous Saturday and Sunday. Again, it is too early to comment definitively on causation, but, if we continue to see that trend, any rise in vaccination will help us as a society as a whole.

I hope that that answers the question, but it might be appropriate to bring in the national clinical director, if he wishes to add something.

The Convener: That would be helpful. I will bring in Professor Leitch.

09:45

Jason Leitch (Scottish Government): Good morning, everybody, and thank you for having me. Convener, I welcome you to your convenership. Like the cabinet secretary, I will endeavour to attend and tell the truth when you ask me to do so. It is good to be back, and I look forward to when we can all be in the one room.

The cabinet secretary has covered the point very well. I ask members to think about the room that they are sitting in. I am not suggesting that we should create certificates for that room, but would members feel more comfortable if everyone in the room was double vaccinated, or not? Vaccinated crowds are safer—there is no doubt about that.

There is a difference between alpha safety and delta safety. In the past few weeks, there has been quite a lot of talk about transmission of the delta variant only being partially reduced by the vaccine. That is true—the vaccine is not as good at doing that as it was for the previous variants; however, it still reduces transmission. Therefore, I am in no doubt, clinically, that a vaccinated crowd is safer than an unvaccinated crowd. It is then a matter of judgment for politicians what they do with that clinical knowledge, and to decide whether they want to have certification in relation to certain pieces of the puzzle, such as where there are crowds, in nightclubs, and when people are moving backwards and forwards to and from stadia. In fact, we are not quite so worried about Parkhead or Ibrox, because they are outdoors. We are worried about the travel to them, and the pubs and houses around them. From a public health perspective, we think that it is sensible to get people vaccinated prior to such travel.

The second point is about incentives. All over the world, there are lots of pieces of work about incentivisation. Some places are giving people £10, and others are giving them travel vouchers. Behavioural science says, "If you want to do certain things, incentives are one of the ways that will enable you to do them".

My third and final point is that we should not forget what vaccination certification is—it is not a replacement for everything else, but another layer. Certification and the list of other mitigations are not mutually exclusive. We are not saying, "Do this, and all the other bets are off"; we are saying,

"We want to do this, but all the other measures, such as wearing face coverings, distancing where you can, and the other things that we have got used to, are still over here".

The Convener: Thank you. Emma Harper wants to come in with a brief supplementary question.

Emma Harper (South Scotland) (SNP): I am not sure how many European or other countries have vaccine certificates, corona passes or green passes, or whatever we want to call them. How many European Union countries have introduced vaccine certificates or their equivalent?

Humza Yousaf: Forgive me, I do not have a note of all those countries in front of me. However, it is not uncommon—a number of European countries have vaccination certification schemes. I will not stray into the politics too much, but they are often countries that have Governments that are centre-left or left-of-centre, or have liberal parties in power. As the convener rightly said, there has been some worry about the encroachment on people's civil liberties, but a number of the countries that have brought in certification schemes have politics that I would say are more left or left of centre.

It is not an unusual step to take, and I also say to Emma Harper that, across the European continent and in other countries far beyond Europe, we have seen certification schemes incentivising vaccination. In France, as soon as the certification scheme was announced, there was a huge spike in the number of people looking to get vaccinated. Therefore, I am hoping that we will see something similar here.

Annie Wells (Glasgow) (Con): Good morning. I want to pick up on the issue of capacity in the NHS, which Paul O'Kane started off on. We have seen waiting times at record levels over the past few weeks and, last week, our largest health board, NHS Greater Glasgow and Clyde, which serves my constituents, warned people not to turn up at the accident and emergency department unless their condition was life threatening. As we move into the winter period, waiting times will be high. What is being done to alleviate the problems now?

Humza Yousaf: Thank you for that excellent question, which raises an issue that is at the heart of what we are planning for and doing at the moment.

The decisions that must be taken are difficult, but they are not unique to Scotland. That is no consolation for your constituents or mine who are waiting for a procedure or are waiting a long time in the A and E department in the Queen Elizabeth university hospital, but it is fair to say that these challenges are being faced across the United Kingdom. Although you are right to note that Scotland's A and E service has had challenges in terms of its performance, it still remains the best performing A and E service across the UK. Again, of course, I accept that that is no consolation to our constituents.

You ask what is being done. The immediate priority is to get through this crisis. We need to reduce community transmission as best we can because, if we do that, we alleviate the pressure that is put on the NHS by Covid. At the moment, we have more than 700 Covid patients in our hospitals. That might seem like a low number but, if you add that to all the other services that the NHS provides, it all begins to add up.

Today, Public Health Scotland should publish some guidance that is focused on primary care and general practitioners in particular. I hope that that guidance will enable more face-to-face consultations to take place at GP surgeries. I know that GPs are already seeing people face to face, but I suspect that, like me, you have been contacted by many constituents who are saying that they are finding it difficult to get face-to-face appointments. That guidance, along with the further investment in primary care that we will make, will help the situation at that end.

I do not need to tell anyone in the committee just how challenging the situation is with ambulances, given the demand on the Scottish Ambulance Service. We have just increased our investment in the service and are already seeing that pay off. I think that more than 60 people were recruited to the service in the north and north-east of Scotland last week.

We are doing what we can on the acute side, including increasing bed capacity and putting in place the NHS recovery plan. No doubt we will come on to this, but the back end is also important, because there are increased levels of delayed discharge. We are working to put in place rapid units that can make the assessments that are necessary in order to get people back into their communities. That includes considering whether it is possible to have a bridging care plan in place that meets those people's needs for a period of time and allows us to work closely with the local authority, the health and social care partnership or the integration joint board to ensure that we can make a full care plan available for that individual.

In short, the point that I am making is that the NHS recovery plan, backed by a £1 billion investment, takes a whole-system approach. There is no point in trying to tackle the situation in A and E on its own; we will have to tackle the entire system if our efforts are to have any effect.

Annie Wells: You have addressed all my questions in one answer, but I will come back to you later in the meeting.

Gillian Mackay (Central Scotland) (Green): I am concerned about recruitment and retention in the NHS recovery plan. You have said that work is under way to recruit at least 1,500 additional front-line staff who are required for the national treatment centres. Are you confident that you will be able to fill those posts?

There have been on-going issues with NHS recruitment, and we have heard that the recruitment of pharmacists into GP surgeries has caused workforce challenges in community pharmacies. There is a risk that moving staff from one part of the NHS to another could cause problems and will not solve anything when it comes to recruitment. How do you plan to avoid that and ensure that there is capacity across all services?

Humza Yousaf: That is a core element of our NHS recovery plan. We have been up front and honest about the situation. We have increased the number of graduate places for medics year on year and we have increased training places for certain parts of the workforce. We are doing all that to increase recruitment as far as possible. However, that will not be enough. We have said in the plan that we will look to conduct ethical international recruitment—I emphasise the word "ethical", because we cannot drain resources from parts of the world that need those resources.

For example, I have had a good conversation with the Academy of Medical Royal Colleges and Faculties in Scotland, which is helping us and will no doubt be a help in relation to ethical international recruitment. The plan also shows that retention is a hugely important part of what we are looking to do. In my conversations with the British Medical Association and the Royal College of General Practitioners, for example, they have stressed the point about retention.

Some of that is within our gift and we are, of course, working hard to see what we can do, but some of it is not within our gift. I have already had exchanges of letters and conversations with the Secretary of State for Health and Social Care, Sajid Javid, with whom I have a good relationship. As members would imagine, it is a frank relationship, but it is a good one. I have already mentioned the fact that pension changes that have been made by the UK Government are an adverse disincentive for those in the medical professions, particularly doctors and GPs. As I said, some of that is within my gift, and we will work hard on that, but some of it is not.

Recruitment and retention are important, and domestic recruitment and ethical international recruitment will be part of our plans.

Gillian Mackay: I want to follow up the point about GPs. Some GPs have expressed concerns about unhelpful messaging, particularly about GP practices being closed during the pandemic. What is the Government doing to try to improve communication with the public regarding the pressure that GPs are currently under and to ensure that everybody knows that they have access to their GP?

Humza Yousaf: We will always do everything that we can from a communications perspective to help to alleviate those pressures. Let us be absolutely clear: GP practices are open, and people can get face-to-face appointments. Some people prefer to have a Near Me video consultation or, indeed, a telephone consultation. I phoned my doctor a couple of weeks ago because I had a bit of an eczema flare-up. That was very easy; I did it in between meetings. I got the ointment that I needed, and that did not take away from my work day. Many people might, like me, prefer doing that, but a number of people would prefer a face-to-face meeting.

GPs are working extraordinarily hard, as everybody in the NHS is, and we owe our GPs at the primary care level all the thanks in the world for the incredible work that they have done. Any suggestion that they are not seeing people face to face because they do not want to is false, and I absolutely reject it. However, a number of members of the public, particularly in our elderly population, want to see a GP face to face. Some of the guidance published today will make that easier.

Gillian Mackay: Representatives of the social care sector have raised concerns that, although there is an NHS recovery plan, there is not a recovery plan for social care. With legislation coming on a national care service, services still need support in the interim period until a national care service is established. Does the Scottish Government recognise the need for a social care recovery plan? What plans are in place to ensure that our social care services have appropriate support as we emerge from the pandemic and before we get national care service legislation enacted?

Humza Yousaf: I agree whole-heartedly with Gillian Mackay. I will make a point that the entire committee knows about. The NHS and social care are interlinked and integrated so, when there is pressure on one part of the system, there is pressure on social care. Those are important points to stress.

On social care, I give as much assurance as I can to Ms Mackay that we are not just waiting for a national care service to be fully operational. It will take until the end of the parliamentary session to get it up and operational. We are taking action now. An example of that is the more than £60 million of funding that we provided to ensure that our social care workers get at least the real living wage. We want to see how we can go even further than that, of course, and that will no doubt be an important topic of conversation in relation to future budgets. We are not waiting around for the national care service.

We are working hard with the social care sector on underoccupancy levels. Ms Mackay will know about the scheme that is in place for payments around underoccupancy, which has existed throughout the pandemic. We are supporting the social care sector where we can. The national care service is hugely important to that. Whereas full terms and conditions can be set consistently across the national health service, that cannot be done across the care sector. With a national care service, which would, of course, be accountable to ministers, we would be able to have a consistency of approach right across the country. Depending on what the final shape of the national care service is, it could involve a full range of care services—not just adult social care but many other care services, such as child services.

We are certainly not waiting around for the national care service. We are working with national care providers to do what we can to help to alleviate the pressure.

10:00

The Convener: Before we move to questions from Sandesh Gulhane, I have a follow-up question. One of the trickier balances that social care providers must strike is between the protection of their residents and clients from infection with Covid, and their psychological and more general wellbeing, which is helped by allowing visitors and contact with loved ones, as well as the social aspect of their work. How can we support social care providers to make those judgment calls?

Humza Yousaf: I could not have articulated the conundrum better myself. That is the challenge. Providers are weighing up incredibly difficult factors. My colleague Kevin Stewart and I have had a number of meetings with family members of people in care homes. It can be sensed from them just how difficult life has been over the past 18 months.

Nobody in the Government and—I say this with absolute confidence—nobody in the care sector wants to keep relatives from visiting a loved one. We understand the challenges of the past 18 months. That desire has to be balanced with considerations to do with what we know is a complex residential setting that involves older people, who we know are more susceptible to the most serious and severe effects of Covid. That is why our clinical director, Public Health Scotland and our other clinicians keep close to the social care sector and advise it regularly on what can be done safely.

However, I will be honest—the circumstances that we find ourselves in at the moment, with high levels of community transmission, are having an impact on our care sector. At the last count, yesterday, I saw that more than 120 care homes have an outbreak of Covid in them. That is not an insignificant number. Therefore, difficult decisions have to be made. I can promise you that Kevin Stewart and I are looking at the situation on a daily basis in an effort to ensure that the rights of relatives of care home residents are paramount, while considering the complex safety issues that are involved in care homes. In addition, of course, we have made a commitment to introduce Anne's law in the first year of the parliamentary session.

The Convener: Anne's law is the ability for a resident to have one close contact—is that correct?

Humza Yousaf: It goes even further than that. In effect, it will give relatives of care home residents rights that are akin to those of care home staff. Of course, the final shape of Anne's law will be up to the consideration of the committee and the Parliament as a whole, but those rights will be embedded in statute.

Sandesh Gulhane (Glasgow) (Con): I draw members' attention to my entry in the register of members' interests: I am a practising GP.

Good morning, cabinet secretary. I wish you a speedy recovery. You should remember that, as we get older, we need to do dynamic warming up, unfortunately. [*Laughter.*] The same goes for me.

I would like to pick up on a comment that you made earlier to Gillian Mackay about pension reform. When I spoke to the BMA, it said that there were things that the Scottish Government could do. The Scottish Government would be able to allow consultants to come out of the pension scheme for a short period—

Humza Yousaf: I seem to have lost my connection. I heard you say that you had spoken to the BMA.

Sandesh Gulhane: I spoke to the BMA, which said that there were things that the Scottish Government could do to help with the pensions issue. The Scottish Government would be able to allow consultants to come out of the pension

scheme for a few months and then go back in, thus negating the problem. That has been done in other places around the UK. Would the cabinet secretary be able to provide me with some information as to why we have not done that yet?

Humza Yousaf: I am more than happy to examine the issue. At my meeting with representatives of the BMA, they raised a number of issues on which they thought the Scottish Government could take action, one of which was the issue that Dr Gulhane mentioned. All of these things undoubtedly come with a cost. There are a number of issues that the BMA and the Royal College of General Practitioners have raised where they think that the Scottish Government could help with retention. We are working closely with the BMA, the RCGP, the Academy of Medical Royal Colleges and Faculties in Scotland and others. Where we can, we will do that. Where those powers exist elsewhere, we will of course work constructively with the UK Government.

I have mentioned that my relationship with the Secretary of State for Health and Social Care is a constructive one. He has promised to consider the issue and to come back to me on it. Where we can take action, we will look to do that. If that involves an additional financial ask, of course that is a decision that we must weigh up in among the other recruitment and retention issues.

The Convener: Before I move to other lines of questioning, I wish to highlight long Covid, which we are now having to grapple with. Many people seem to be suffering its effects. What is the overall strategy for assisting people who are suffering the complex symptoms of long Covid?

Humza Yousaf: This answer will be slightly unhelpful, but I hope to be able to give a little bit more detail on that next week. We were due to have our debate on the NHS and social care this week but, because of the need to have a parliamentary debate on the certification scheme, which was rightly brought forward, we will be having that debate on the NHS next week. I hope to say more next week about our strategy on long Covid and about what we are considering doing to bolster the local response to the long-term effects of Covid.

We are currently trying to ensure that the pathways that we have provide care as close to home as possible. That does not rule out the possibility of setting up long Covid clinics—health boards could do that tomorrow if they wanted—but the model of long Covid clinics does not necessarily work everywhere. In NHS Highland, for example, there may be challenges in having a long Covid clinic in one part of the Highlands given the travel and the distances that require to be covered, which could cause problems for people suffering the long-term effects of Covid in other parts of the Highlands. That one model does not always fit, although that does not mean that it does not have merit. I reiterate that, if a health board wanted to create a specialist clinic, it could do so.

The point is that there is a current referral pathway, and there is an implementation note with GPs on the long-term effects of Covid. Essentially, using existing services, we are trying to get people the best treatment that they can get in the long term, and as close to their home as possible. We are also trying to understand more about long Covid, which is why we are investing in research. Our understanding of long Covid and of the long-term effects of Covid is evolving day by day.

The Convener: I will now go back to Sandesh Gulhane, who has some questions about staffing.

Sandesh Gulhane: I would like to ask the cabinet secretary about the 10 per cent increase in key services, which is part of the plan. What is the timescale for delivering that?

Humza Yousaf: That is all in our NHS recovery plan. We will meet that 10 per cent increase for out-patient activity by the end of the parliamentary session. By the end of the session, in-patient and day-case activity should increase by closer to 20 per cent. You will find that on page 5 of the recovery plan, where we go into detail about how we will increase in-patient activity, out-patient activity and diagnostic activity year on year.

I am still waiting for the detail, but I note that the UK Government is due to make an announcement on its plans today and, from what I have heard communicated in the media, my understanding is that it will also try to increase capacity by 10 per cent. I am pleased that the UK Government has seen that ambition in our recovery plan and will try to match it.

I will repeat what I said to Mr O'Kane earlier: we will of course be ambitious, but we will also be realistic about the timescales that it will take to clear those backlogs and get our NHS back to complete normality.

Sandesh Gulhane: From your answer, we are looking at five years to get to that 10 per cent target. My worry is that we continue to fall back as we try to achieve that. One of the key aspects of the aims is the redesign of care pathways. Could you tell me a little more about how you plan to redesign care pathways to achieve that target?

Humza Yousaf: In relation to out-patient activity, you are right, it will take us the parliamentary term to reach that 10 per cent. In relation to additional in-patient and day-case activity, we hope to get there by 2022-23, so I hope that we will get to that 10 per cent a bit

earlier. The significant increases in diagnostics are important.

I missed part of your question, but was it on particular pathways or referral pathways? Forgive me, my connection seems to be timing out.

Sandesh Gulhane: It was about the redesign of care pathways. The paper says that one of the key aspects would be the redesign of care pathways, so I ask for more details about that.

Humza Yousaf: In relation to our cancer pathways, we are already trying our best to get early diagnostics, which is a key part of trying to alleviate the pressures on the system. We know that if we get people that care earlier, particularly in relation to cancer treatment, they have a better chance of recovery, which means that they will be less likely to end up in our hospitals for longer. Our early cancer diagnostic centres are clearly a part of that. The earlier that we can get people referred into the system, such as early cancer diagnostic centres, the better chance we have of alleviating that pressure and seeing more people through the system. Obviously, we already have some of those early cancer diagnostic centres up and running.

Sandesh Gulhane: The Association of Anaesthetists think that there more than 1,000 shortages across the country, probably closer to 2,000, and the Royal College of Nursing says that there are 3,000 nursing vacancies. Even with the significant increases that are in the paper, we will still barely achieve parity let alone increase the workforce once we consider the natural turnaround and people who are leaving who stayed a bit longer because of Covid. How can we address that?

Humza Yousaf: That is a very good question. I perhaps touched on the issue in my answer to Ms Mackay. I will not pretend to you; it would be insulting to your and the public's intelligence for me to suggest that we are able to meet those ambitious recruitment targets simply by domestic recruitment. We will do that, but we will also try to recruit from other parts of the common travel area. It is clear that ethical international recruitment will be part of what we do.

In relation to training, do we get the absolute most out of the current staffing cohort or can we train them to an even higher level? Can we incentivise them to stay for longer? A number of the stakeholder member organisations that I suspect Dr Gulhane and committee members have met tell me that retention is a key issue, and we are working hard on how we can retain people. Where those powers are within our gift, of course we have to use them, and where they are in the gift of other Governments, we will work constructively with them, because these are common challenges. The challenges that GPs and consultants in Scotland face are probably very similar to those faced in other parts of the UK.

Yes, we should invest in the pipeline and make sure that there is an increase in training places and graduate places; increased domestic recruitment and retention and ethical international recruitment are also part of the mix.

10:15

Paul O'Kane: We are having a discussion at the moment about our long-term future planning, and I think that a lot of our work for many years to come will be dominated by workforce planning issues and ensuring that we get the recovery right. Will you say something about the imminent challenges of the winter? We are about to embark on a difficult winter period in the NHS. I note that the national workforce strategy will be published in December, but by then we will be into the winter pressures, and a lot of the recommendations will take time to flow through.

Will you comment on the pressures on staffing in the winter? The question relates not just to the NHS, but also to social care, because it is important to be able to discharge people from hospital more quickly and to have care packages in place. I am keen to understand the cabinet secretary's thinking on that.

Humza Yousaf: Again, my connection timed out briefly. I think that I got the gist of Mr O'Kane's question, but if I do not answer any part of it, I am happy to come back to him.

Mr O'Kane is absolutely right. Nobody waits for a workforce plan to come at the end of the year before taking immediate action. That is why our staffing levels are the highest that they have ever been. A record number of whole-time equivalents are working in our NHS. An additional 5,000 WTE staff are working in our NHS this year compared with last year. We are investing in staffing right here and now. It is important to make that point.

We have had ambitious plans right across the NHS. As you know, we have targets to increase the number of GPs, paramedics, mental health workers, community link workers and paramedics in the Scottish Ambulance Service, and that investment is happening here and now.

This is where I briefly lost my connection, but I think that part of the question was about social care. We are also working really hard with the sector to see what we can do to retain current staff, but also to do a bit of marketing and communication to incentivise people into social care and to ensure that those who study social care go on to work in the area rather than going off to another profession. We are working with them

while they are still doing their courses at university or college in order to try to attract them to stay in social care.

However, I will be very frank and honest with you: that side of things—recruitment into social care—is probably one of the elements that gives me the most significant concern, because we do not have the same leaders in social care that we have in the NHS.

Emma Harper: I have a question on what the cabinet secretary said about cancer pathways and the modernising patient pathways approach. The diagnostic centre in Dumfries and Galloway is one of the first such centres and I believe that it is doing really well in fast-tracking people who do not have concrete symptoms of cancer. That is something that has been introduced that is working quite well, I understand.

I am interested in whether the modernising patient pathways programme is looking at cancer pathways in general. As an example, I note that people in Stranraer and Wigtownshire go to Edinburgh for their radiotherapy, which involves longer journey and travel times than if they were going to the Beatson west of Scotland cancer centre, which they basically drive past. Is the programme looking at shorter journeys and travel times and a different overall approach to the cancer pathway programme?

Humza Yousaf: In short, yes. Forgive me—I will need to double check when we are hoping to publish the refreshed framework for effective cancer management, but I hope it will be in a matter of weeks, and that will go into the detail of exactly what Ms Harper mentioned: making sure that we have the right treatment at the right time and in the right place for people.

We recognise that there are challenges in rural areas with cancer referral and pathways. Let us be honest: even pre-pandemic, there were challenges. The refreshed framework—the effective cancer management framework—will help to address some of those issues.

Gillian Mackay: You have laid out the measures for GP recruitment, but I want to ask about out-of-hours services. The pressure on GPs who do out-of-hours work is particularly acute at the moment because of the pressures elsewhere in the NHS. Those GPs are a particularly dedicated workforce. What else can we do to prioritise GPs' wellbeing so that they will want to continue to contribute towards out-of-hours services? While we recover from Covid, pressures in other areas undoubtedly mean that more people are accessing out-of-hours services than was previously the case.

Humza Yousaf: Those are really important questions. We are looking proactively at how we can further incentivise out-of-hours working, because we know how challenging that is and how important it is to the recovery. As Ms Mackay will appreciate, we have to work with the trade unions and staff-side representatives on that to ensure that they are comfortable with what is being proposed. We are looking to finalise a lot of the detail on that.

An important issue that Ms Mackay touches on, which I am happy to say more about if we get into this in more detail, is wellbeing. Wellbeing is important not just for out-of-hours staff but for everybody. My first visit as health secretary was in Lanarkshire, and I was blown away by the testimony that I heard from healthcare workers and NHS staff more generally. As members can imagine, I spoke to porters, cleaning staff, doctors, nurses and everybody in between, and they all told me the same thing. It did not matter what their job was, they were knackered. They were really tired because of the past 18 months. That is why we are investing £8 million in their wellbeing. For brevity, I will not go into detail right now, but a whole range of services is available, some of which are very specialist. If we are going to ask NHS staff to help us with the recovery, which is vital, we are going to have to make sure that their wellbeing is paramount.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): Emma Harper mentioned cancer. Has there been any exploration of the idea of lung cancer screening? It is the most common cancer, and people experiencing deprivation are three times more likely to suffer from it. Has any work been done on that, or is there any intention to carry out any work on that?

Humza Yousaf: If it is okay, I will pass that question over to the national clinical director. Ms Callaghan is absolutely right. When it comes to the more challenging cancer pathways, we look at the most common cancers. The largest cause of preventable death is smoking, and cancers associated with smoking, of which lung cancer is one. I will ask the national clinical director to say a little more about lung cancer specifically.

Jason Leitch: We have a process by which we decide what to screen for. Our screening committee looks at the most recent global data, the risk benefit of screening and what form that screening should take. Is it a blood test? Is it an X-ray? Is it a mammogram? What is the mechanism by which we would find the cancers? Presently, that data suggests that we should not do routine, population-level lung cancer screening for any particular age group.

However, if that changes, or if the screening committee or the world sees something to change that, we would of course do it. There are other places where the screening might happen after a

GP makes a specific choice based on symptoms, previous employment, age and so on, but population-level screening is quite a rare thing and we do it only for a small number of cancers because the risk has to outweigh the benefit of doing it at a broader level.

To my knowledge, we are not looking at that in any further depth, but the cabinet secretary and I will ask the screening committee to ensure that I have not missed anything, and I will write to you.

The Convener: Paul O'Kane has a cancer-related question while we are on that topic.

Paul O'Kane: I am keen to hear more about early cancer diagnostic centres, which have already been alluded to. We know about the delays in setting them up. They add a lot of value through early diagnosis and opening up new pathways for people who do not have clear-cut symptoms, and there is a sense that we could utilise them in every health board area. I am keen to understand from the cabinet secretary what the plans are to roll out centres further and what the timescales for that are.

Humza Yousaf: I can give—[*Inaudible*.]—in writing if that is helpful. The first early cancer diagnostic centres are of course already open and, with such initiatives, it is so important that we do a proper evaluation before we decide to roll them out even further. We have procured external evaluation from an academic institution, and that will provide important monitoring and, I hope, positive evaluation.

I went to the early cancer diagnostic centre at the Victoria hospital in Fife and I was really impressed. It had been open only for a few weeks but staff there had already detected early cancers in a number of patients. Although cases were small in number, the impact on the NHS and those individuals and their families will have been great.

The first centres need to bed in, and we need to get the data and analyse what is happening. The evaluation will inform the roll-out of further centres.

I note that early cancer diagnostic centres are one tool; I was also at the centre for sustainable delivery that is based at the Golden Jubilee hospital. If the committee would like to visit the CFSD, staff there will be more than happy to host you—I highly recommend a visit. They are looking at a variety of innovative technologies, such as colon capsules, that will help with not just detection of cancers but the speed at which that can be done and the comfort of the patient while it is being done. The ECDCs are important, but they are one tool among a range of tools that I am hoping to deploy to help us with the diagnostic part of the cancer journey. We know that it is the diagnostic side that is letting us down so that we do not meet the 62-day target.

The Convener: We move on to questions on mental health.

Evelyn Tweed (Stirling) (SNP): I state for the record that I am a councillor at Stirling Council.

My questions are on child and adolescent mental health services. A lot of anxious constituents have been in touch with me on that subject and I know that there is a problem not only in the Stirling constituency but across Scotland. Will you give us a flavour of how the recovery plan will address the issue?

10:30

Humza Yousaf: I thank Evelyn Tweed for that important question. I suspect that she is not alone among MSPs and that every one of us receives difficult cases in our inboxes and at our advice surgeries from desperate family members on the criticality of their children's mental health.

I have a number of things to say on this, but I will try to be brief. I can go into more detail if Evelyn Tweed or other members want me to. First, I note that we are investing in services that I would say are pre-CAMHS, in that they are designed to be accessed at a much earlier stage, before people get to the point at which CAMHS crisis intervention is needed. That programme of local interventions is, again, designed to be suitable for whatever the local need is. For example, it might be different in Stirling compared with Selkirk or other parts of the country. That investment is important.

Some of our approach in the area will include ensuring that we have the appropriate services in place in schools. I am happy to expand on what we have done to ensure that we are getting more and more resource into schools.

As Evelyn Tweed will know, we set up a CAMHS task force that gave us an evaluation of the service and made recommendations, and we are investing quite significantly in CAMHS—some details of that are included in the NHS recovery plan. Some of that investment will address staff recruitment. We intend to provide funding to increase recruitment to CAMHS by 320 additional mental health workers. That increase in the staff cohort will undoubtedly work.

I will be honest here: the wait for CAMHS treatment is unacceptable. We are not meeting the 90 per cent standard at the moment and I am afraid that we were not meeting it before the pandemic, either. We have therefore invested additional funding of £29.2 million to NHS boards specifically to target CAMHS, with £4.25 million of that being focused directly on those who are currently on the CAMHS waiting list.

There is a lot more that I could say but, for the sake of brevity, I will hand back to Evelyn Tweed, who I am sure has follow-up questions.

Evelyn Tweed: I note that nearly a quarter of CAMHS referrals are rejected. What happens to the children and young people whose referrals are rejected?

Humza Yousaf: That is a long-standing issue that was raised by a number of people in the previous parliamentary session, too. That is why we set up an independent group to consider in detail the issue of rejected referrals. An audit was done of rejected referrals and a number of recommendations were made in 2018. We accepted all the recommendations of that group. We have implemented the service specifications for CAMHS, which set out the standards of service that children, young people and their families should expect, and we have funded boards to implement that specification. Within that specification, a clear expectation is set out in black and white that services should be appropriately re-engaged, where necessary.

As I said, we have provided about £15 million of additional funding to local authorities to deliver locally based mental health interventions and wellbeing support for five to 24-year-olds. Those services are linked closely to CAMHS, so signposting can be ensured. That means that, if a referral is rejected by CAMHS, the individual is not just left to their own devices but is signposted to one of those local interventions.

Ultimately, decisions about whether referrals are accepted are not for ministers to make; those are important clinical decisions. However, I hope that no young person would be left without any support whatsoever, given the mental health challenges that they might be facing.

Stephanie Callaghan: I should probably have said earlier that I am a councillor at South Lanarkshire Council. I am also the parent of an autistic child, and I will follow on from Evelyn Tweed's question with a question about the parents of children with autism spectrum disorder.

In a number of cases where kids have been turned down by CAMHS, the parents will have waited a long time for the referral to come through, and there can be a lot of hope behind that. It can be devastating for them and for the children who are refused CAMHS support. You have spoken about the audit and about lots of things being implemented, but I am still hearing that same story from parents. What assurance can you give the parents of children with autism spectrum disorder and other additional support needs that we will find suitable pathways to support those children?

Humza Yousaf: Thank you not only for the question, but for disclosing how the issue might have affected you personally and other families that you might know well, who have a child who has autism.

If you do not mind, I will take that question away and consider it further. I would be deeply worried if I was to look into the data in detail and discover that rejected referrals were disproportionately affecting children who have autism. If that was happening, it would give me a real level of concern and I would have to look at why that was happening.

Donna Bell, the director of mental health and mental wellbeing, might want to add something.

Donna Bell (Scottish Government): I do not have data before me that sets out the split between neurodevelopmental referrals and other referrals, but we can seek out that information. We have a similar service specification for new developmental conditions that sets out the same expectations that are in place for broader CAMHS referrals, and I am happy to share that with the committee in due course.

The Convener: We move on to questions about health inequalities.

Paul O'Kane: The pandemic has undoubtedly exacerbated health inequalities. We have all seen quantitative and qualitative data that shows that. I also think that public health has never been so in focus for people in Scotland and so sharply understood in our homes on a daily basis.

Cabinet secretary, with regard to the learning from the pandemic, what key interventions do you envisage as we look ahead and move beyond Covid into recovery? For example, do you support the suggestion in the paper on non-communicable diseases that was published yesterday by the British Heart Foundation and nine other charities that there should be quick interventions on issues such as the advertising of e-cigarettes, the monitoring of sugar content in foods and better planning of smoking cessation and obesity services?

Humza Yousaf: Again, I will try to give a flavour of the position, and if Mr O'Kane wants me to give more detail on a specific point, I am more than happy to do that.

First, we know that many of the health inequalities that our constituents face are linked to poverty. That is why the role that the Deputy First Minister has in relation to Covid recovery is important. He is convening weekly meetings between and across portfolios, at which cabinet secretaries and ministers can work closely together. We have always done that, but the meetings enable us to do it with extra energy and additional focus on ensuring that we are working in

a cross-portfolio way and not compartmentalising our efforts or working in silos.

For example, the work of the Cabinet Secretary for Education and Skills has an impact on my portfolio and, in turn, that impact could end up having an impact on the justice portfolio. We all know the interlinkages that exist. From a Government perspective, I assure Mr O'Kane that we are working on these issues across Government in a way that has a determined focus, and that is helped by the role that the Deputy First Minister plays.

We also know that the pandemic has not been felt equally. It would be wrong to say, "We are all in it together". Although that has some truth to it, some people have undoubtedly been hit far harder by the pandemic than, for example, somebody like me who, thank goodness, is in a comfortable position in terms of their health—notwithstanding my challenges at this moment—and their financial circumstances.

We are absolutely focused on ensuring that, when it comes to recovery, some of the inequalities that have existed in the system are weeded out. How will we do that? The women's health plan is an example of that, with its 66 actions that look to address women's health. We know that one aspect of women's health is that women face greater inequalities when it comes to their health. We are also looking to publish shortly our immediate priority plan for race equality. That will go into a level of detail about how we intend to work through the inequalities that exist among our minority communities. We know that black and minority ethnic communities are often hit harder when it comes to health inequalities, particularly when compared with their white Scottish counterparts. We are taking a range of actions.

Mr O'Kane rightly mentioned some important health interventions in areas from smoking cessation to plans to tackle obesity, particularly among children. I will not go into detail on those unless Mr O'Kane wishes me to, but I have been concerned throughout the pandemic about some of the work that we had done and good progress that we had made around smoking cessation, lowering alcohol consumption and tackling obesity. I am afraid that we have not been able to make progress on some of those things during the pandemic because of the immediate need to deal with Covid. I am very keen—and have been working hard—to ensure that we are now focused again on some of those important public health interventions.

Carol Mochan (South Scotland) (Lab): Cabinet secretary, I was heartened to hear your response about dealing with the root causes, which is important in this area. Following on from Paul O'Kane's questions, I will ask about childhood obesity and approaches to young people's health. Do you agree that it is important that we get those things right early on so that we can look forward to people having long and healthy lives, and that it is important that we target areas of deprivation in order to ensure that people across all communities have a fair start in life?

Humza Yousaf: I am not surprised that Ms Mochan gets to the heart of the issue, given her experience before she became an MSP. It is clear from her raising those very issues in Parliament that she has an understanding of the area.

I am extremely focused on ensuring that we weed out some of the inequalities that have existed in the system. It might sound a challenging thing to say in the middle of a global pandemic but, because we have to remobilise and rebuild from the pandemic, it presents an opportunity to do that in a way that might not have been possible before.

We have the very ambitious target, which I think is achievable, of halving childhood obesity by 2030. We are going to do that through a range of actions. We have to make healthy food easier to access for people who live in the areas of highest deprivation. I clearly remember that, 10 years ago, when I was on the Public Audit Committee before I was a minister, we went into the heart of Drumchapel and had a session at the health centre there. One of the users of the centre said, "Don't you politicians come and lecture me about healthy eating when I have two or three takeaways right beside me and they cost half what it would cost me to go to a supermarket to get a healthy meal". She was right to put that challenge to us.

10:45

In the past 10 years, we have managed to make some progress and we have seen some of the effects of that. We have also commissioned research in order to understand in a lot more detail how health systems can support pregnant women. After all, we want to do this as early as possible pre-birth and to focus on children in the early years to see whether, for example, we can put more interventions in place to ensure that they eat well. We have made £650,000 available to NHS boards and community projects to work with families in order to prevent childhood obesity, and in the current financial year we will invest £3 million in improving young people's weight management services.

Moreover, as I said, we will work constructively with the UK Government, where we can. As you know, it has responsibility for television advertising. I welcome its commitment to banning junk food advertisements before the 9 pm watershed, but I want it to go even further and look

at how online advertising of less healthy food and drink can be restricted, too. In fairness to the UK Government, it is keen to work with the devolved Administrations on such shared issues and agendas.

The Convener: Are you content with that response, Ms Mochan, or would you like to ask a follow-up question?

Carol Mochan: I do not have any follow-up questions on that, convener.

The Convener: In that case, I call Stephanie Callaghan to ask about health inequalities.

Stephanie Callaghan: Pre-pandemic, adverse childhood experiences were possibly the biggest public health issue facing Scotland, with poverty being a strong reinforcing factor. Evidence suggests that the resulting toxic stress leads to health problems in adulthood, including heart attacks, strokes and addiction. Indeed, it can even lead to increased cancer rates. Given that there being increased ACEs could have a huge impact on the NHS, how will you look to knit together health and social care partnerships, local authorities and public health agencies in order to develop policies that can provide support and prevention and, down the line, save people from going to the NHS with such problems?

Humza Yousaf: The work on ACEs is something that I, as Cabinet Secretary for Health and Social Care, and my ministerial and Cabinet colleagues pore over regularly, and it informs many of the interventions and initiatives that we look to bring forward; after all, ACEs impact not only on health.

We are, understandably, focusing on health in this discussion. However, I should say that when, as Cabinet Secretary for Justice, I saw who was in my prisons and who was in our care at Polmont young offenders institution, it was hardly surprising—although, of course, it was deeply disturbing and regrettable—to find that the number of ACEs that people in our prison system had had far outweighed the number that had been suffered by the average person in the population outside prisons. Adverse childhood experiences not only have massive health impacts; they also have negative and adverse impacts right across society, let alone on the Government's priorities.

I assure Ms Callaghan that we give considerable weight to the research and evidence on that. I know that some of the evidence can be controversial and that some people have criticised the adverse childhood experiences model. However, the Government believes in the general principle that if we intervene as early as possible pre-birth—I am thinking of initiatives that I have already mentioned, including the baby box—to give every child the best start in life, we have a better chance of weeding out the inequalities that undoubtedly have the health and other societal impacts that Ms Callaghan has rightly highlighted.

Stephanie Callaghan: That is really good to hear, but what worries me the most is that sometimes it is all like a big jigsaw in which the pieces do not fit together properly, so they have to be hammered into place. I suppose that the focus of my question is on how we get the various organisations to work together on developing policy to ensure that it works as effectively as possible.

Humza Yousaf: If it gives any comfort to Ms Callaghan, I point out that we have extremely regular contact with people on the ground. We can set all the national policy in the world, but we know that local delivery partners are key to what we are trying to do. That is why our investment is hugely focused on local delivery partners at NHS board level, IJBs, health and social care partnerships, and community-based and third sector organisations. They were doing good work pre-pandemic—let alone the good work that they have done during the pandemic. If it is any comfort to Ms Callaghan, I give her an absolute assurance that every single cabinet secretary and minister works closely with our local delivery partners. The Deputy First Minister co-ordinates a lot of that work.

Emma Harper: I want to pick up on what Paul O'Kane said earlier about yesterday's report, by charities including the British Heart Foundation, on non-communicable disease priorities. Prevention of ill health is something that we could be focusing on. In the previous session, we received evidence about £90 million having been spent on complications due to type 2 diabetes. Preventing such complications in the first place, perhaps through social prescribing, would be a way of keeping people out of hospital.

We could also look at pulmonary rehabilitation. Will you continue to support wider implementation of pulmonary rehab, and what work will be done to consider social prescribing as a way to reduce ill-health in the first place?

Humza Yousaf: I apologise for not answering that part of Mr O'Kane's question; I was not trying in any way to be evasive.

I have seen the report on non-communicable diseases that was published yesterday. It will take time to look at the recommendations, but I will give considerable weight to anything that comes from the British Heart Foundation and the many other charities that were involved in the report. I will give the report my attention.

Emma Harper has a track record of speaking about issues relating to diabetes and her own

personal journey in that regard. There is probably little for me to say other than that I agree with her.

On social prescribing more broadly, there was a committee report on the matter in the previous session of Parliament. In the 2020 programme for government, we included a commitment

"to establish a short life working group to examine social prescribing of physical activity"

and sport. The group's remit will be to

"identify and communicate examples of best practice, and co-produce resources for practitioners".

The establishment of the group has been delayed by the pandemic—which, I hope members agree, is understandable. However, my officials are currently considering how we will take forward the short-life working group, which will look at the predecessor committee's report and its recommendations on social prescribing.

The Convener: We will shortly be moving on to technology questions from David Torrance, but Emma wants to come back in.

Emma Harper: As others have mentioned their interests, I should say that I am still a registered nurse. I want to ensure that that is on the record.

The Convener: Thank you. We now move on to questions about technology that is being used during the pandemic, and its future.

David Torrance (Kirkcaldy) (SNP): Good morning, cabinet secretary.

In session 5, the Health and Sport Committee reported on the creation of a national digital platform and problems around data sharing. There has been a huge increase in use of technology. Before the pandemic, there were around 1,200 Near Me and video consultations per month; there are now 12,000 per week. What progress is being made on use of a single digital platform and on the problems around data sharing?

Humza Yousaf: First and foremost, we have seen effective deployment of technological solutions throughout the pandemic. We have talked a lot about the Near Me video technology that exists; I am sure that we will continue to do so. The number of consultations that are now taking place using that platform is a positive thing—it shows that practitioners and patients have confidence in the system.

I am relatively new to my post, but my observation is that we still have a fair way to go when it comes to interoperability of our digital systems. David Torrance was right to reference the national digital service that was established in 2018. As he said, that will deliver the national digital platform. We have always been up front about the fact that that will take some time, but the pandemic has undoubtedly delayed some of the necessary work. However, in effect the aim remains the same. The key aim is interoperability—using different information systems, devices and applications to access information and ensuring that we can integrate it in a co-ordinated way. The system must work across organisations, regions, NHS boards and national boundaries in order to transfer information seamlessly and to optimise interventions for individuals.

A range of actions have been taken and are being taken. I can go into more detail on any of them, if you want; I can write to the committee on that, because the list of what we are doing across various systems is quite lengthy. We are making progress but, clearly, some of that progress has been affected by the pandemic.

David Torrance: Earlier, you talked to Gillian Mackay about face-to-face consultations with GPs. Is there a guarantee that any individual who wants a face-to-face consultation with any part of the NHS can get one?

Humza Yousaf: Ultimately, that is the position that we want to reach. Of course, we have to remind ourselves that we are in the midst of a global pandemic and that there are important infection prevention measures still in place. GPs are seeing patients face to face, and we want them to increase the number of those consultations, with focus being on the people who are in most need. However, ultimately, the short answer to the question is yes—we want to get to that position.

I should point out that in surveys that we have conducted we have found that more than 80 per cent of people prefer digital or telephone appointments with their GPs. There might be lots of reasons for that—perhaps such appointments interfere less with people's days, for example. However, for those who prefer face-to-face consultations, we want to get to a position at which they have that opportunity. I will say, however, that we have to be mindful that we are still in the midst of a global pandemic and are still contending with a highly transmissible virus.

David Torrance: On use of new technologies and platforms, what safeguards have been put in place to protect patient data?

Humza Yousaf: We know how important that is for patients, customers and everyone in society. Whether we are talking about an app that gets Uber Eats to deliver food to a person's house or an app that is linked to a public service such as health, ethical and secure storage of the data that the app gathers is hugely important.

One of the first meetings that I had as health secretary was with our cybersecurity team, who had brought in an external consultant who was

helping us to work through the security in our NHS systems. They are doing a good amount of detailed work.

We are going to publish a refreshed digital health and care strategy that will commit to the development of our first ever dedicated data strategy for health and social care, and will include detailed consideration of how to increase our citizens' trust in data sharing, and of how to ensure that there is transparency in the system. We need to unlock the value of health and care data in a way that ensures that the data can be safeguarded and that there is full transparency over how it is used.

The security of the data is important; cybersecurity testing has already been carried out for all the other major systems, including Near Me. With regard to our Covid certification—which is a very topical issue—we will ensure that we have up-to-date security provision in place, particularly when the app is ready to go live at the end of this month.

The Convener: Sandesh Gulhane has a short supplementary question.

11:00

Sandesh Gulhane: Given all that you are taking forward, can you tell us who will be the Caldicott guardian for the data that will be collected? If guardians are to be doctors and GPs, how we will ensure security?

Humza Yousaf: That depends on what system we are talking about, although we obviously have to comply with all the regulations in statute and, ultimately, we are accountable to the Information Commissioner's Office with regard to how we use that data. That is exceptionally important. Who the data controller is will depend on the system in question, but if it gives Dr Gulhane comfort, I can tell him that we already engage regularly with the ICO on development and introduction of new systems. Moreover, our cybersecurity centre of excellence is working hand in glove with practitioners on the ground not only on our current systems but on the development of new systems.

Of course, I do not need to tell Dr Gulhane any of this—he will be well aware from his other role in primary care that our practitioners on the ground are usually well aware of their responsibilities in handling data. However, I am more than happy to hear suggestions if we need to do more, particularly with regard to the development of new systems.

The Convener: We were scheduled to finish around now, but if members approve, we will continue so that we can cover the very important topic of women's health. We should finish in about 15 minutes, but I really want to give the issue an airing.

First, I declare that I was on the cross-party group on women's health. That group called for a women's health plan, so I am pleased that such a plan will—we hope—be in the programme for government. A number of members have questions on the plan. I call Gillian Mackay first.

Gillian Mackay: When will we see an implementation plan for the women's health plan, and will it include specific timescales for things coming forward?

Humza Yousaf: First, I am entirely at your behest, convener, but I can stay on for an extra half an hour, to 11.30 am. I know that you have other committee business to get on with, but I just want to say that my time is not so constrained, so I am happy to stay in front of the committee for as long as is necessary.

On the women's health plan—[*Interruption*.] I am sorry—my daughter just dropped my crutches.

The women's health plan, which sets out 66 actions, contains short, medium and long-term implementation goals. Short-term delivery means within one year, medium-term means one to three years and long-term means three or more years. We plan to establish an implementation board; that will be key, because we all recognise that a strategy is only as good as its implementation. In fact, writing the strategy is often the easy part. Implementation will be vital. The implementation board will look at key milestones and measures of success; we hope that it will meet before the end of this year and that its implementation plan will be finalised by spring 2022. [*Interruption*.] Please forgive the interjection.

I hope that that reassures Ms Mackay. I am happy to provide more information in writing, if she needs it.

The Convener: It is lovely to hear your daughter cheering on the idea of a women's health plan, cabinet secretary. Do you have any follow-up questions, Gillian?

Gillian Mackay: That is me finished, convener.

The Convener: I am interested in the focus on health with regard to the menopause. I note, for example, that the women's health plan recommends the setting up of specialist clinics to deal with menopause. Do you have any more detail on that, cabinet secretary? I know that the plan has been out for only a couple of weeks, but what are the proposed provisions for specialist centres for women who have a more complex type of menopause?

Humza Yousaf: Thank you, convener. I recognise the role that you have played in relation

to the women's health plan and in getting us to this point. I know that you have often felt like a lone voice, having spoken about the matter for many years, so I am really pleased that it has entered the mainstream consciousness. That is why our women's health plan is so important.

The implementation of the strategy will be critical. As I just mentioned in my answer to Ms Mackay, the implementation board will ensure that key milestones and measures of success are established.

We are already working at local health board level, because if we have a strategy at national level that is not there at the local level, it will not be delivered. Key to the effort will be the women's health champion that every health board will have in place. The champions will drive forward strategic change at local level. They will promote the women's health plan where that is needed, and they will support a network of local women's health experts and leaders.

We hope to appoint a national women's health champion next year. At the moment, though, we will ensure that we have local structures in place, because what will work in a menopause clinic in one part of the country might be different to what will work in another—urban settings versus rural settings, for example. We want to leave what a menopause clinic should look like largely to local health boards, and we will have a specific person in each health board to drive change and ensure that it is happening at local delivery level.

The Convener: Is the idea to reach out to members of the wider public who might have been through the healthcare system in relation to menopause and to get feedback, through public consultation, on what the plan should look like?

Humza Yousaf: Ideally, that would be the best way to do it. We know that getting people with lived experience to co-design not just our policies but our services is very important. From your involvement, convener, you will know that the women's health plan had at its heart a co-design process that involved women who had lived experience of a range of conditions. The women's health plan's coverage of menopause, periods, endometriosis and a number of other health aspects was informed by women who had lived experience of them.

Ultimately, the best way to develop clinics that are specifically for menopause is by hearing from women who have suffered some of its more challenging effects so that we can make sure that the service is built around them. There is no point in building the service structure, then fitting people into it. It is much better to hear from people and devise a system that is built around them.

The Convener: Thank you.

Evelyn Tweed: In a recent debate about women's health, I spoke, in particular, about my journey with endometriosis. It was wonderful to hear that so many women across Scotland welcome the Government's plans for making progress on the issue, but can you give more detail on how we are going to reduce diagnosis times? Women are very interested in that.

Humza Yousaf: I thank Ms Tweed for speaking about her own experiences. I do not take it lightly when people share their health experiences; it is a difficult thing to do, particularly when standing in a parliamentary chamber.

Our women's health plan goes into some detail on how we will do that. However, the best thing that I can do for Ms Tweed is give her detail of what the implementation board will seek to do, because the implementation of the actions will be different in different local health board areas. One size does not always fit all, so there will be different pathways to referral. The diagnostic side of endometriosis is something that we have to concentrate on. Funding will be available for that, including through the investment that accompanies the women's health plan.

The implementation board will be absolutely vital to that work. Ultimately, it will decide on the best way to implement each of the actions. I can promise Ms Tweed that some of them will be short-term actions, but, equally, some of them will be long-term actions. I cannot wave a magic wand to improve things overnight—I know that that is not the expectation. However, particularly with regard to endometriosis, some of those actions will be taken at speed, because we know not only just how much women suffer but how many challenges there are around the diagnostics.

I am happy to write to the committee in more detail on implementation of the women's health plan, if that is acceptable to Ms Tweed and the committee, but it would be helpful if I could do that at a time when we have a bit more detail about the implementation board.

The Convener: That would be helpful. Of course, we will come back to the women's health plan in detail at a later point.

Emma Harper: I have a quick question, which could be dealt with as part of the response to Evelyn Tweed's question that you send us.

The cervical cancer self-screening research that is being done at the moment is interesting. I got involved in that because NHS Dumfries and Galloway was taking forward the self-sampling procedure in order to capture the 6,000 women who had defaulted on their cervical smear test. I would be interested in an update on how the research is progressing. Are we likely to see a roll-out of self-screening for cervical cancer, which is

particularly focused on human papillomavirus infection, in Scotland?

Humza Yousaf: Forgive me, but I do not have that information to hand. I will get an update on that research and write to the committee.

My concern around cervical screening involves some of the issues that my colleague Maree Todd updated Parliament on before the summer recess. She will provide Parliament with a further update shortly. My concern is that we do not allow the issues that she addressed then, as unfortunate and regrettable as they are, to detract from the importance of women coming forward for cervical screening. We know what a positive impact the cervical screening programme has had on detecting cervical cancer early, which leads to earlier treatment and, in turn, a more positive outcome. Therefore, I do not want those issues to detract from the positive benefits of the screening programme.

As I said, I do not have the most up-to-date analysis of that research, which is still being undertaken. When we have that, I will be happy to write to update the committee.

Carol Mochan: On the back of Evelyn Tweed's question, I have a brief question about the length of time that it takes for women to be diagnosed with endometriosis. Women speak to me about the fact that it has been a long journey, and clinicians have acknowledged that they perhaps do not have the necessary expertise. I am sure that this issue will be part of the plan, but it is important that we share expertise among clinicians and that, where necessary, appropriate training is available.

Humza Yousaf: I agree. I should have said in my response to Evelyn Tweed's question that one of the actions in the plan is to commission endometriosis research. You are right to say that a number of people—clinicians and women—want to know more about the condition and understand it better. The research is there to develop better treatment and management, and, hopefully, a cure. That is one of the actions that are part of the women's health plan. I hope that that gives you some comfort.

The Convener: That rounds off our questions on the women's health plan, but Annie Wells has a final question on the health and wellbeing of staff.

Annie Wells: Thank you for the opportunity to ask this question, convener.

Cabinet secretary, you rightly started off this evidence session by praising and thanking our front-line NHS and social care staff. I think that everyone in Scotland would agree with you on that. You also said that they are "knackered". I do not think that that is just a physical health issue; it is also a mental health and wellbeing issue. Therefore, can you say what is in place to support the pandemic-related mental health and wellbeing issues of our NHS and social care staff? Will staff have protected time to use the wellbeing support that is available?

11:15

Humza Yousaf: Annie Wells is right to say that the issue is not just one of physical health—it is absolutely also about mental health.

I vividly remember a conversation that I had, during a visit to a hospital, with a nurse who was quite senior and worked in the high-dependency unit. As somebody who is not a clinician, I had wrongly assumed that someone at her level of seniority in nursing would, unfortunately, have seen a number of people pass away during her career but, actually, she had not. However, at the beginning of the pandemic, the high-dependency unit was overwhelmed with so many people coming in that the amount of death that she saw at that stage was greater than she had seen in her entire career. She said that that had had a huge impact on her mental health. Maybe I am stating the obvious, but that is something that had not registered with me, as a non-clinician. I agree entirely with Ms Wells's assessment that there is a huge mental health impact on staff.

What are we doing about it? There is £8 million going into wellbeing, across a range of initiatives. We have the 24/7 national wellbeing helpline, the national wellbeing hub, coaching for wellbeing and the workforce specialist service. All those resources are being used, and used well. We know that the national wellbeing hub has been used more than 115,000 times by health and care staff, and that the workforce specialist service—the clue is in the name—is being used as well.

With regard to protected time, I am absolutely open to that discussion. I am more than happy to take that suggestion away and discuss it not only with health boards, but with our trade unions and staff-side representatives. I am certainly open-minded on that point. It would obviously come with some challenges, given the current pressures on the health service that we have all spoken about, but if we want our NHS to recover, staff wellbeing must be at the heart of that.

The additional funding of £2 million that we allocated to support the primary care and social care workforce should help local teams to secure time for reflection and recovery to meet the identified needs. That funding could also be used for locum cover and backfilling costs. On the broader issue of protected time for wellbeing, I am happy to look at what more we can do in that regard.

The Convener: We have come to the end of our questions. I thank you for your time this morning, cabinet secretary, and I thank Caroline Lamb, Professor Leitch and Donna Bell, too. We look forward to seeing you again for more updates on a lot of the things that you have mentioned today. Before I let you go, do you want to say anything else to the committee about your priorities for the future?

Humza Yousaf: There are a couple of issues that we did not touch on, which the committee may follow up with other ministerial colleagues. For example, the national mission on tackling drug deaths is also a clear priority for me. My ministerial colleague Angela Constance is taking forward that work, but I want to give you an assurance on that issue, because I know how important it is to every member of the committee. Ms Constance and I are working extremely closely on that. If you want me to come back to the committee, I will do so, or if you want Ms Constance to attend, I am sure that she will come to the committee to talk about that.

I just want to assure you, convener, that, as cabinet secretary, I am working hard on that. I am more than happy to come back to the committee if you want me to do so, even at particularly short notice, especially given the nature of the pandemic that we are dealing with, in which things can move extremely quickly. I will make myself available to the committee whenever it is a suitable time for you.

The Convener: We have Ms Constance coming before the committee next week, and we look forward to asking her questions on that specific area. Again, I thank you for your time this morning.

Subordinate Legislation

National Health Service (Travelling Expenses and Remission of Charges) (Scotland) (No 2) Amendment Regulations 2021 (SSI 2021/241)

Milk and Healthy Snack Scheme (Scotland) Amendment (No 2) Regulations 2021 (SSI 2021/274)

11:19

The Convener: Item 3 is consideration of subordinate legislation. There are two negative instruments for us to consider. The first instrument amends the National Health Service (Travelling Expenses and Remission of Charges) (Scotland) (No 2) Regulations 2003 to make free dental care available to people who are aged between 18 and 25 years. The second instrument amends the Milk and Healthy Snack Scheme (Scotland) Regulations 2021. Its aim is to clarify and address technical issues with the operation of the milk and healthy snack scheme.

The Delegated Powers and Law Reform Committee considered the two instruments, and both instruments were reported under reporting ground (j), for their failure to comply with the 28-day laying period. No motions to annul have been received in relation to the instruments.

Do members have any comments on either of the instruments?

Emma Harper: I guess that the instruments breached section 28(2) of the Interpretation and Legislative Reform (Scotland) Act 2010 because of Covid. Is that right?

The Convener: Yes, that is correct—it was due to the pandemic.

I see that there are no other comments or questions. Therefore, I propose that the committee makes no recommendations in relation to these negative instruments. Does any member disagree?

I see that there is full agreement.

At our next meeting on 14 September, the committee will hear from the Minister for Drugs Policy, Angela Constance, on her priorities for session 6. That concludes the public part of our meeting today.

11:22

Meeting continued in private until 11:39.

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