OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 12 September 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

© Parliamentary copyright. Scottish Parliamentary Corporate Body

Information on the Scottish Parliament's copyright policy can be found on the website - www.parliament.scot or by contacting Public Information on 0131 348 5000

Tuesday 12 September 2023

CONTENTS

HEALTH, SOCIAL CARE AND SPORT COMMITTEE
25th Meeting 2023, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (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)
*Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

James Dornan (Glasgow Cathcart) (SNP) (Committee Substitute)
Caroline Lamb (Scottish Government)
Michael Matheson (Cabinet Secretary for NHS Recovery, Health and Social Care)
Christine McLaughlin (Scottish Government)
Jenni Minto (Minister for Public Health and Women's Health)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 12 September 2023

[The Convener opened the meeting at 09:15]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 25th meeting in 2023 of the Health, Social Care and Sport Committee. I have received apologies from Stephanie Callaghan, for whom James Dornan MSP will join us as a substitute.

The first item on our agenda is to decide whether to take items 3 to 5 in private. Do members agree to do so?

Members *indicated agreement.*

Programme for Government 2023-24

The Convener: The second item on our agenda is a session with the Cabinet Secretary for NHS Recovery, Health and Social Care. The cabinet secretary is accompanied by the Minister for Public Health and Women's Health for this agenda item.

Over the summer recess, using the Your Priorities online platform, the committee invited members of the public to suggest questions that they would like us to ask the cabinet secretary. Today's session is an opportunity for members to put some of those questions to the cabinet secretary and to ask questions about the 2023-24 programme for government, which was published last week.

I welcome our witnesses from the Scottish Government. Michael Matheson is the Cabinet Secretary for NHS Recovery, Health and Social Care; Jenni Minto is the Minister for Public Health and Women's Health; Caroline Lamb is the chief executive of NHS Scotland and director general for health and social care; and Christine McLaughlin is the director of population health.

We will move straight to questions. Cabinet secretary, we are all very aware of the current situation regarding Covid-19 and the emerging variants that we are seeing. What data is the Government using to maintain vigilance about Covid-19, given the rise in cases and the new variants of concern?

The Cabinet Secretary for NHS Recovery, Health and Social Care (Michael Matheson): Good morning, convener. Public Health Scotland continues to monitor Covid-19 levels and is testing for the new variants. That is largely being carried out through people who have been admitted into our hospitals, who might present with symptoms, and that is being used to inform our approach to how we continue to manage Covid-19.

Members will be aware that the decision was made a number of months ago, in line with other parts of the United Kingdom and countries globally, to manage Covid-19 in the way that we would manage any other seasonal infection. That continues to be our approach, but we are monitoring very closely any changes to the pattern and rates of infections. That will inform any further decisions that we make about any changes to our approach that we might have to make.

We will also continue to keep in place a range of testing arrangements for individuals who are being discharged from hospital into social care settings, for example. We have taken a slightly different approach on that from some parts of the UK in

order to maintain a level of vigilance. That means that a level of testing is still taking place for vulnerable categories of patients, particularly if they are going to be transferred into social care settings.

The Convener: How is the Scottish Government monitoring the newer variants that we are seeing, particularly the one that is causing concern just now?

Michael Matheson: We are engaged with the chief medical officer, who is engaged with the other CMOs across the UK, and work is being taken forward through the genome sequencing process, which is, obviously, operating at international level. I do not know the full clinical details around that, but work is being carried out to test the impact of the existing vaccination programme against the new variant.

I also understand that vaccine producers are monitoring whether they have to make any amendments to their existing vaccines, but all that work to monitor the on-going situation is being taken forward across the UK and globally. At this stage, we are still waiting for those reports to come back, but there is a level of vigilance in place to ensure that our decisions are made on an informed evidence base.

The Convener: Thank you. I call James Dornan, who has some questions on a similar theme.

James Dornan (Glasgow Cathcart) (SNP): Thank you, convener, and good morning, cabinet secretary, minister and members of the panel.

Given the continuing presence of the Covid-19 virus, how does the Government plan to address transmission among particularly vulnerable people and protect them, through, for example, ventilation and clean-air requirements?

Michael Matheson: Going back to my earlier point, I make it clear that the clinical advice not just at a Scottish and UK levels but at the global level is that Covid-19 should now be managed as a seasonal infection and in the way that we manage other seasonal infections such as flu, because the level of vaccinations that have now been provided to the population gives us much greater protection. Our intention is to continue to manage Covid-19 on that basis.

If the clinical advice changes at some point and we have to take further action, we will respond to that. However, the present advice is that we should continue to manage things as we are managing them and in the way that we manage other seasonal infections.

James Dornan: I have a couple of questions about long Covid. We have read in the responses to the Your Priorities consultation complaints about people with long Covid not being treated properly with regard to access to testing, best-in-class support and treatment, and public awareness education. What is your response to that?

Michael Matheson: Is this in relation to people with long Covid not having access to—

James Dornan: There have been complaints about people with long Covid not being treated properly with regard to access to testing, best-in-class support and treatment, and about public awareness education of the condition.

Michael Matheson: Before I bring in Ms Minto, I should say that a range of work is being taken forward by boards through the long Covid treatment pathways, which are being delivered as part of the £10 million that we have made available for long Covid services. I think that nine of our health boards have their long Covid treatment pathways in place, and around five are still developing them.

For example, NHS Greater Glasgow and Clyde's long Covid service allows general practitioners to make direct referrals of patients for assessment and for appropriate treatment options to be made available. We have also allowed boards to design services that best reflect their local circumstances and what they believe to be most appropriate for patients in their areas.

A range of services is available, but one of the challenges has been to ensure that clinicians know that such services are available to refer patients to. Some of our boards have therefore been undertaking work with colleagues across general practice to ensure that they are aware of how patients can be referred directly to these services. Some will also accept self-referrals from patients for assessment and for an appropriate treatment programme to be put in place that reflects their individual circumstances.

I do not know whether Ms Minto, who leads on some of this area of work, has anything more to say.

The Minister for Public Health and Women's Health (Jenni Minto): Thank you, cabinet secretary, and thanks to James Dornan for his question.

In the summer, I spent some time with a group providing peer support to people living with long Covid. I and my officials found that incredibly helpful, and we listened to the concerns that were being raised. What the cabinet secretary talked about and the fact that we have allowed health boards to ensure that they provide the services that are most important for the people who live in their vicinity was passed on to the group but it was helpful for me to hear what they said.

In the next couple of weeks, I have two meetings. One is with Long Covid Scotland, and the other is with children and families who have been affected by long Covid. That is important for informing the work as we go forward.

James Dornan: I did not hear much in your answers about public awareness education. Will you give us a bit more detail about what you intend to do or are doing to make the public aware of long Covid?

Jenni Minto: I heard from people who live with long Covid that there needs to be more public awareness of the conditions that they live with. I heard from one gentleman in his early 70s who had been fit and used to go out walking a lot. It now takes him more than half an hour to walk half a mile.

There is a need for better knowledge on the part of the wider public about the impacts of long Covid. I was pleased that I had officials with me on that visit and will have them with me in my meetings next week and the following week. That means that they have heard about that need, and I am speaking to them about how we can improve awareness of long Covid in the population.

James Dornan: I have one more question for you, minister, or for the cabinet secretary. What are your views on the suggestion that was made in relation to your priorities that we lag well behind European Union treatment regimes?

Michael Matheson: Do you mean for long Covid?

James Dornan: Yes.

Michael Matheson: We are on a path to understanding long Covid much more effectively. You might be aware that quite a bit of global research is taking place to understand the impact of long Covid and the most appropriate treatments for it.

My understanding is that, as it stands, no single treatment type is appropriate for long Covid patients. We often have to try to provide a holistic form of treatment. For example, the service that is being offered in Glasgow—the long Covid pathway—has a range of different clinical inputs, from physiotherapy, through occupational therapy to psychological services. All of those are about trying to address some of the issues that can present with patients who experience long Covid.

It is fair to say that we are in a learning environment on how we treat long Covid. From some of the patients with long Covid whom I have met, I know that its presentation is variable and they often have different needs. That is why some of our NHS boards look to provide services much more holistically with a range of different supports that can be provided to patients and to tailor those to best reflect patients' circumstances.

We are all learning more about long Covid. That will continue to influence how we intend to deliver services for patients with long Covid in the future.

James Dornan: Thanks for that, cabinet secretary. Just back on the—

The Convener: Thanks, James, but we need to move on.

James Dornan: Okay, convener. My apologies.

Emma Harper (South Scotland) (SNP): Good morning to youse all. I have a quick supplementary. I was reading about long Covid on NHS Inform. There are 16 different languages for people who might need support. Might the Government consider ensuring that people of different ethnicities and languages know that that is available by using social media or whatever?

Jenni Minto: That is a good suggestion, Ms Harper, and I will take it away.

09:30

Sandesh Gulhane (Glasgow) (Con): Good morning, cabinet secretary. I have heard some heart-breaking stories from 11-year-olds with long Covid who are unable to get out of bed, asking their parents if this is all that their lives are going to be and saying that it is just not worth continuing. What would you say to such a child and their family? What tangible help have you put in place and will be put in place for kids with long Covid?

Michael Matheson: We have previously discussed the services that have been provided for long Covid, including some of the pilots that have been taking place in England and how some of that could inform our learning here in Scotland. I know that some health boards have looked at that and learned from it. For example, NHS Greater Glasgow and Clyde has been using some of the long Covid funding to bring in paediatric occupational therapists to work specifically with children who are experiencing long Covid, and also, where necessary, using paediatric physiotherapists to support those children.

Health boards are trying to adapt their services to make sure that young people who are experiencing long Covid have access to clinical teams that can provide them with the support that they require, and they are using some of their core funding to design such adaptations. NHS Greater Glasgow and Clyde, for example, now has some paediatric services to address the needs of young people with long Covid.

If the member has an individual case that he wants me to look into, and he wants to share the details with me after this meeting, I am more than

happy to do that. Long Covid does not just affect adults; it also affects children, and services are being designed that will make sure that we also meet the needs of those young people.

Sandesh Gulhane: You are right to say that it affects young people. Has the Scottish Government made any assessment of the economic impact of long Covid?

Michael Matheson: It is difficult to assess the number of people who have long Covid. Some of the patients whom I have met who are experiencing long Covid have seen a detrimental impact on their employment. In some cases, they have had to give up their employment because they are no longer able to continue with the job that they were in. Others have been able to adapt their working environment so that they can accommodate their issues with long Covid, and others still have been able to continue with their employment.

The situation is therefore variable, and, at this stage, I could not give you a figure for the economic impact of long Covid and we have not carried out an assessment to enable us to do so. Again, it will have an impact on individuals in different ways and it will depend upon employers being prepared, as they should be, to make reasonable adaptations for employees who have a long-term condition so that they can continue with their employment. It is important that employers do that while it is necessary.

Sandesh Gulhane: There are health boards that do not have a long Covid pathway in place. When do you expect that to happen, and will you be putting pressure on health boards to come up with those pathways quickly?

Michael Matheson: The majority of health boards have those pathways in place now. Those that do not are carrying out the work at the moment and I would expect those pathways to be in place this year. The funding has been made available for them this year as part of the £10 million programme so there is no reason for the boards not to achieve that. We will continue to monitor their progress.

David Torrance (Kirkcaldy) (SNP): Good morning, everyone. On NHS recovery, why have waiting times not returned to pre-pandemic levels?

Michael Matheson: A big part of that is because we have to deal with the backlog that built up during the pandemic. During the pandemic, a lot of our elective and diagnostic procedures had to be stopped and that resulted in a significant backlog that we are having to manage within existing capacity. New people are being added to the lists, but we are still dealing with the people who were already on the lists. That accumulation has made the situation extremely challenging and it will take some time for us to recover to the pre-pandemic levels.

Also, in some areas, the level of referrals has increased quite markedly. For example, we have seen a significant increase—of almost 45 per cent in some areas—in the number of referrals to our cancer pathways, which is way above what it was before the pandemic. We are having to deal not only with the backlog but, in some areas, with a significant increase in the number of referrals into those diagnostic pathways, which has an impact on waiting times overall. You will be aware that boards are making steady progress, particularly around long waits—we have seen a steady decline in outpatient and in-patient long waits—and we are continuing to work with boards around that, but it will take some time for us to be able to get back to pre-pandemic levels.

We are also working through the Centre for Sustainable Delivery on a programme of work to ensure that we are maximising capacity in our services. The centre is carrying out work with a new digital tool to consider how we can maximise the use of theatre times, which could potentially give us an additional 30 per cent capacity. Through the Centre for Sustainable Delivery, we are trying to get consistency across boards around how they maximise capacity and the use of resources in their existing services, because some of them are not operating at their pre-pandemic capacity and we need to ensure that we get greater efficiency there.

The issue involves that combination—the history, the increased referral rates and our trying to ensure that we maximise the capacity that we have in the existing system in order to use it to its full potential.

David Torrance: What impact are national treatment centres having on waiting times for orthopaedic and cataract operations, and on unscheduled care and patient flow in secondary care?

Michael Matheson: The national treatment centre in your area of Fife is helping to deliver on-going improvements in the delivery of orthopaedic and ophthalmology services, which will help to reduce the waits. I do not know the exact data for Fife, but I know that the Highland NTC is ahead of schedule with its programme, which is helping to reduce waits for patients in that health board area and will support NHS Grampian, too, because its patients will go to Highland NTC as well. Once we bring on phase 2, the NTCs at the NHS Golden Jubilee and at the Forth Valley hospital will give us additional capacity, which will help to reduce waiting times in those individual board areas. However, that work is taking place in the wider context of the increase in demand that we are facing.

On the impact that NTCs will have on unscheduled care, one of the challenges that one always has is that acute priorities can often displace elective work. The benefit of having NTCs is that they are a protected environment and are for elective purposes, which gives greater certainty around the amount of elective work that can be taken forward, as it can otherwise be buffeted around in the general setting of acute priorities, where unscheduled work is having to take priority over elective procedures for clinical reasons. The NTC environment gives us a level of protection in the system, which will assist boards much more effectively with their planning not just over months but over a whole year.

David Torrance: Are national treatment centres being considered for any other specific areas, such as cancer treatment, which would be part of the transformation of cancer care?

Michael Matheson: The plan was to have 10 NTCs across the country, and we are moving towards phase 2 of that work. The work is being considered in our capital programme, which is being reviewed because of the cuts to our capital budget, and is primarily focused on elective procedures—predominantly around orthopaedics, ophthalmology, endoscopies in some cases, and so on—rather than acute care. Caroline Lamb can say whether anything has been considered around cancer care with NTCs—I do not know off the top of my head.

Caroline Lamb (Scottish Government): The national treatment centre programme was designed to deliver elective care. As the cabinet secretary said, it is important to be able to separate that from unscheduled care, so that elective care is not impacted when there is real pressure on unscheduled care.

We have introduced a number of early assessment centres for cancer, bringing together rapid assessment and treatment centres. That has been our focus for cancer.

Evelyn Tweed (Stirling) (SNP): Social care staff will benefit from a pay uplift to £12 per hour, which will mean an increase of more than £2,000 a year for some staff. What difference do you anticipate that making?

Michael Matheson: Our social care staff are critical in supporting and sustaining our health and social care systems, which are interlinked and are key to each other. The social care setting has traditionally been undervalued, which has been reflected in the rate of pay within social care compared to that in healthcare.

We have taken forward a programme of work to make social care a more attractive working environment and to reflect the value of our social care staff, which has resulted in an increase in their pay. Pay has been increased to £12 an hour over the past two years. We have already taken it up to £10.90, and the pay increase in the sector will be equivalent to more than 14 per cent in two years.

The objective behind that is to make care a more attractive profession and to support the retention of social care staff to make the sector more resilient. The principal objective is to try to get more people into care and to support and encourage those working there to remain there in future by providing them with better pay.

Evelyn Tweed: The Scottish Government has avoided strikes in the national health service by negotiating pay deals for NHS staff and for trainee doctors and dentists. Scotland is the only country in the UK to have avoided strikes thus far, which is good news. How will that help the Scottish NHS and the Scottish people?

Michael Matheson: Any form of industrial action is hugely disruptive to our NHS, not only to staff and to the management process but to patients. To see that, we only have to look at England, where there has been repeated industrial action and where I believe that more than 7.5 million patients are on waiting lists and that almost a million procedures and appointments have been cancelled as a result. That is the immediate impact, and there will be a cumulative impact caused by backlogs in the system.

The system and staff are already under enormous pressure and adding persistent industrial action to that demoralises staff even further and makes them feel undervalued, bringing all the challenges that go with that. My deal with the junior doctors involved acknowledging and recognising the real challenges that they face because of pay erosion, and we managed to negotiate an agreement with them to avoid industrial action.

My big concern with industrial action is that it is not only disruptive to patients but demoralises people who work in the system even further, which has consequent challenges, and puts people off working in the NHS as a result of the disruption and difficulties.

09:45

There is a monetary cost to settling those matters. However, we would create even bigger challenges for ourselves if we did not try to address the issues. The challenges that we would have faced from industrial action would have been even greater—they would have been worse—than dealing with the financial challenges arising from the pay settlement.

Tess White (North East Scotland) (Con): I have three questions for the cabinet secretary. The chair of the British Medical Association has said that Scotland needs 2,000 general practitioners, yet you are struggling to find 800. How will you deliver the primary services that patients deserve?

Michael Matheson: First, I will just correct you. We are not struggling to find 800 GPs—we are ahead of the trajectory to recruit that number. Also, in relation to recruiting to GP specialty training, this year, we not only reached 100 per cent but even more applied for the training than the spaces that were available.

We are in a strong position to deliver on our commitment to recruit 800 GPs during this parliamentary session and to increase the number of GPs in training. I note that, this year, all specialty options were taken.

In addition, we have been expanding medical training places. We have made a commitment to increase the number of medical students in Scottish medical schools by 500. This year, we have increased that by 300 places and we are on target to increase places by another 200. Believe it or not, the BMA has asked us to slow down a bit, to make sure that there is capacity in the system to train those medical students.

We face challenges in relation to our medical workforce—I would not want to give people the impression that we do not—but it would be wrong to give the impression that we are struggling, because we have been able to recruit to the places that have been made available for general practice and for the training programmes.

However, we must continue to do more, because general practice is under huge pressure. A big part of that is not just the GP workforce but the multidisciplinary team that we have in primary care. A key part of what we must do in primary care is to ensure that we have a broad range of healthcare professionals that can meet patients' needs and can meet the increasing demands that primary care will face. Having that combination will be key to ensuring that we meet those demands as best we can.

Tess White: My follow-up question is about GP recruitment in rural areas. That seems to be a major issue, and rural healthcare is in crisis. Things are so bad that—we brought this issue up at committee last week—the community of Braemar is trying to headhunt its own GP, because the local practice has struggled to recruit a suitable candidate. Residents had to take action into their own hands and do their own recruitment.

In Aberdeenshire alone, five practices are now managed by the Aberdeen health and social care partnership and that figure is about to increase to six. The wheels are definitely off the bus in the north-east in terms of the provision of healthcare by rural GP practices.

I have two questions on that. First, why has not the Scottish National Party done more to address this crisis in primary care and GPs and to make rural Scotland more attractive to health professionals? Secondly, does the Scottish Government intend to look at the 2018 GP contract in the context of rural practices?

Michael Matheson: I will deal with those issues in turn. There are challenges in rural general practice—there have been for many years, particularly in single-handed practices. When GPs in such practices choose to leave or to retire, it can be difficult to recruit replacements. That can be for a variety of different reasons, but I agree and accept that there is a challenge in some parts of rural Scotland.

On what we are doing to address some of those issues, first, we have the Scottish graduate entry medicine—ScotGEM—programme, which is about recruiting and encouraging doctors to work in our rural environments. We also have the bursary programme—I wrongly called it the "golden hello", but that is not what it is—which is, again, about supporting individuals, who may be GPs, to work in rural areas by giving them financial support, or a financial incentive, as part of the programme. The third thing that we are doing is—as the committee will be aware—setting up the centre for remote and rural healthcare, which is a programme designed to consider specifically how we can create and deliver greater resilience, in particular in primary care, to deal with the systemic challenges that we have in recruiting people into our rural areas. That combination of programmes to retain and support people in rural settings, and the creation of those financial incentives, is all aimed at supporting getting people into general practice in our remote and rural areas.

On the point around the number of practices that are now in the NHS, that has happened historically. Over the years, some people give up their contract, which is taken over by the NHS. That happens in urban as well as in rural areas.

Yesterday I had a meeting with the health and social care partnership in Grampian and the chairs of the integration joint boards, so I know that they are taking forward a programme of work to look at creating a much more sustainable approach to the delivery of primary care within the NHS Grampian area, and that they have a plan to deal with some of the very specific issues that they are experiencing within the NHS Grampian area. They expect to have that programme of work completed by the end of this year. I have explained to them that I want them to look at how they can work in an innovative way using the existing system to deal

with some of the particular challenges that they have in their area.

Tess White: But, cabinet secretary, do you think that it is acceptable that a local community has to take recruitment into its own hands to find a GP?

Michael Matheson: The responsibility for the delivery of primary care within the local area, and the contract, is directly with the health board. I would expect the local community to engage with the health board, and the health board to engage with them, around how they are addressing the issue of concern around ensuring adequate general practice services in their area. I would expect the health board to be proactive in doing that. If it is not and there is a need for it to do so, I would be more than happy to ensure that it engages with the community in Braemar. It is important that there is a level of local understanding of the most appropriate way to deliver services locally in the primary care setting.

Tess White: There is a big difference between 800 and 2,000. The BMA says that we need to recruit 2,000 GPs in Scotland. Do you dispute that figure?

Michael Matheson: I do not know where the 2,000 figure from the BMA comes from, or from what analysis. I understand that groups such as the BMA lobby and push for what they think is the best approach. I always engage with the BMA in a meaningful way, and, in fact, I think that I am meeting it to discuss primary care this afternoon.

We will continue to look at what more we can do to support primary care as a critical part of our healthcare system, which will be under even greater demand in the years ahead, given the demographics that we have as a country and the disease burden that we face. I will always look to see where there is more that we can do, and engage with the BMA around the issues that it raises to understand the rationale behind the calls that it makes.

Tess White: In relation to workforce planning, this is not rocket science. You do not have to wait to find out whether someone is retiring; if there were Scotland-wide workforce planning, you would be able to understand the flows, see when people would be retiring and therefore know at the front end how many people you had to recruit.

The launch of the national centre for rural and remote health and social care is now months overdue, and the workforce recruitment strategy has been kicked down the road until 2024. It is good that you actually recognise that workforce planning is required, but the fact is that we are kicking the recruitment strategy into next year.

Michael Matheson: The challenge is that people can choose to leave general practice at different points in their careers. It is not always the case that they choose to retire when they get to retirement age; some might choose to do so earlier. The challenge, therefore, is trying to plan to ensure that we have the right intake into medical education and the right cohort of specialities available to allow people to specialise after their foundation years and to do all that in a way that reflects future need and demand.

Moreover, the vast majority of our general practitioners are independent contractors, and they can choose to change the hours that they work, retire earlier and so on. There are variables in there that we cannot always control, but we have to try to balance the system to ensure that the training and education and the move into specialities are sufficient to meet what we think will be the intended need. At local level, the health boards, which have the direct contracts with general practice, will be monitoring the situation and trying to put in place the right arrangements that might be necessary, should the numbers of GPs in their area change or should there be a significant increase in their population, to ensure that they have the right level of services to meet local demand.

The challenge is that if we try to do what we think should happen in Grampian, say, remotely here in Edinburgh, we will not always get that right, because we will not be as close to the community as we need to be. That is why designing local services is best left to local health boards, because they can engage with local communities, understand exactly what is needed locally and therefore try to design the most effective services. It is about trying to balance the system at a national and a local level, and to do so over the long term. It is challenging, but it is exactly what we are trying to do.

Carol Mochan (South Scotland) (Lab): Good morning. I have three questions about the safe staffing legislation, which has already been passed. First, will it be implemented in the first half of next year?

Michael Matheson: Yes, that is our intention. We are engaging with the unions, in particular, to manage implementation. I think, from the discussions that have been had, that there is a desire on everyone's part to deliver implementation within that timeframe, but in a way that does not create unintended problems for existing NHS staff. So far, our engagement with the unions has been very much about trying to get the balance right. I do not know whether Caroline Lamb has anything more to say, but that is still our intention. We are just trying to ensure that we take

the employee side with us in order to get the balance right.

Caroline Lamb: This is not about our waiting until April then suddenly implementing the legislation. All our NHS boards are testing various aspects of the legislation and its operationalisation—that is, how it is put into practice. That will provide us with some important learning. As the cabinet secretary has said, that is being done very much in partnership with our trade unions.

Carol Mochan: That is excellent. My second question was to be on engagement with trade unions, so I am really pleased to hear what you have said. Obviously, I have been liaising with them myself.

My final question is on the link between the staffing legislation and the Patient Safety Commissioner for Scotland Bill. We managed to lodge some amendments on that at stage 2, so a result should be that both work together. What discussions or thoughts have you had on that?

Michael Matheson: I am not familiar with the amendments that you are referring to, but I am more than happy to have a look at them and to consider how they will work in relation to safe staffing levels.

Do you want to say something about that, Ms Minto?

Jenni Minto: Stage 3 of the bill is coming up in the next couple of weeks. That will provide an opportunity for us to take cognisance of what you have said and to look at how we incorporate it in the debate. I am sure that Ms Mochan will cover the issue in the contributions that she makes in that debate.

10:00

Carol Mochan: It is very helpful to know that you are still committed to that. We want to make sure that the link between safe staffing and safe patient outcomes is taken forward. That is great. Thank you.

The Convener: Emma Harper has a short supplementary question.

Emma Harper: My question is on the Scottish graduate entry medicine programme, which has been really successful in Dumfries and Galloway. My understanding is that retention there has been fab. Cabinet secretary, is ScotGEM unique to Scotland? I know that there are general practitioner issues across the four United Kingdom nations. Are you aware of whether the other nations are considering a ScotGEM-equivalent programme? Scotland leads the way on the matter.

Michael Matheson: Yes, it does. I am aware that Dumfries and Galloway has benefited from the ScotGEM programme. I raised the issue at the last meeting of the four nations' health ministers, where we discussed recruitment and retention issues—in particular, issues in our more rural areas. I highlighted the ScotGEM programme to the other ministers and I have offered to share our information on how the programme operates and the benefits that we have had from it. There is interest in looking at how the ScotGEM programme has worked.

The Convener: I will stay with Emma Harper for our next theme.

Emma Harper: One of our themes is how we tackle obesity. I am interested in the issue and have recently asked questions in the chamber regarding ultraprocessed foods and high-fat, high-sugar and high-salt foods. Carlos Monteiro, who is a professor of nutrition and public health in Brazil, has done some great research, and books by Chris Van Tulleken and Henry Dimbleby that talk about ultraprocessed foods have recently been popular. How can we understand more about the relationships between foods, and not just their sugar and fat content? This question is for the minister, because it is in the public health portfolio. I am interested in the powers that are available to us in Scotland in regulation of marketing and sales of those types of foods? Can you give us an update on work that is being taken forward?

Jenni Minto: I had a lot of discussions on such issues with my officials over the summer. We will do a consultation in the autumn on foods that are high in fat, sugar or salt, and we are consulting on which foods to concentrate on—crisps, confectionery, cakes and other foods. We will probably also consult on promotions, including meal deals, unlimited refills and location of products in stores. We will consider all those things. Over the summer when I was shopping, at the end of my shopping I got a voucher for a cake, and I thought, "Why didn't I have the option of a voucher for a banana?" We are thinking about things such as that.

Emma Harper commented on the fact that rather than introduce a bill, we are producing regulations. We believe that that will allow us to move swiftly and efficiently. Circumstances changed, which allowed us to bring in regulations as opposed to a bill, and we are working at pace on the timescales.

I know the two publications on ultraprocessed foods that Emma Harper mentioned. There have also been a number of articles in newspapers on the topic, and there are a number of podcasts about ultraprocessed foods. I was in a meeting last week with Food Standards Scotland and Public Health Scotland at which I raised the issue

as something on which I would like to get more information. We look at evidence from the scientific advisory committee on nutrition, but there is currently no specific evidence on ultraprocessed foods. The Scottish Government bases decisions and policies on evidence. We need to carry out further engagement and consultation on ultraprocessed foods. I have asked my officials to look at that.

Emma Harper: Our briefing papers talk about the "cost of obesity". I know that the language is changing around that and that rather than labelling someone as having a disease we are now using less stigmatising language and saying that they are a person who is

"living with overweight or obesity".

Should we be thinking about that and ensuring that people understand that we should not blame people for something that might be not their fault but could be because of issues to do with poverty and access to fruit and vegetables in neighbourhoods where local shops do not have such food. What work is being done to destigmatise the language around obesity so that we can support people in food choices and in access to food?

Jenni Minto: That is a really important question that was highlighted to me yesterday when I heard from a mother whose son had been described as "fat" and "obese," which had given him a dreadful lack of confidence.

You are absolutely right that language is incredibly important, as is how we work with local authorities, schools and other public bodies to ensure that the message is spread across our services. One example is the good food nation plan, which talks about ensuring that children have the opportunity to eat good healthy food. I saw that in operation last week at a primary school in Edinburgh, where they were talking about breakfast and healthy foods, such as Weetabix and fresh fruit. There is a whole conversation to be had around language, which is important in education centres as well as across the general public. We are very cognisant of that.

Emma Harper: Finally, will the Scottish Government's provision of free school meals for primary-school age children, which it is expanding, help to tackle what is being called an environment of "commerciogenic malnutrition", because of the way in which big manufacturers are targeting unhealthy choices at young folk? Will widening of access to free school meals by the Scottish Government help to address some of the issues with overweight young people?

Jenni Minto: Absolutely. As they say, a healthy start to the day—breakfast—is so important. The free school meals are also helping to support families who might not be able to afford the foods that we would like them to be able to eat. That is part of a whole Scottish Government policy to transform the food environment. As you will know, we recognise the need to bring people out of poverty in order to improve the general health of the population.

Emma Harper: Thank you.

Carol Mochan: Minister, I think that we all agree that with the right policies we could halve childhood obesity in Scotland by 2030. I would like to understand why we are going into another consultation process. Given the evidence that we have, why cannot we consider legislation? Has pressure been put on you and the Government not to introduce primary legislation in the area? We know that we could change outcomes for a large part of the population.

Jenni Minto: No pressure has been put on us by other organisations not to introduce a bill, then an act, on the issue. A change in circumstances and evidence from England has allowed us to introduce measures using regulations.

When we bring in any food regulations, there must be proper and robust consultation, which is what we are doing now to ensure that we bring in the right policies, based on evidence, to improve people's ability to buy the right food.

Carol Mochan: The process has been going on for a number of years and is time-sensitive. Can you commit to ensuring that the matter is a top priority for the Government in terms of business?

Jenni Minto: The subject is certainly a priority: it sits in my portfolio and is a priority within public health. I look at the matter from an education perspective. The joy is clear on the faces of some children, who might never have tried various fruits. That is why it is important that we work with education services to ensure that families understand the importance of food. Food should be a pleasure, and not just something that people have when they are watching television. That is where I am coming from. There is a huge challenge in changing the health and food environment across Scotland.

Carol Mochan: I have one more tiny question. I am interested in the daily mile. How much commitment is there across Scotland to the daily mile? Is it is still a priority?

Jenni Minto: I was in Elgin during the summer, which was the first place where I had come across the daily mile. People at the health centre there spoke about the importance of exercise, which is just as important as what we eat. Staff at the health centre explained how they are supporting families, and not only with the daily mile. People aged from eight months to 80 are attending the

health centre to get support with fitness, whether through the daily mile or something more physical such as swimming or weight training. That is really important.

The Convener: Evelyn Tweed has a very brief supplementary question.

Evelyn Tweed: During the cost of living crisis, some people are, out of necessity, having to eat highly processed food that is probably not that good for them. There has been an increase in the number of people suffering from preventable diseases such as rickets. Has the Scottish Government thought about how we will deal with that issue?

Jenni Minto: I have learned while working in my portfolio that we can never be fully confident that we have eradicated a condition or disease. I have regular meetings with officials who work on various diseases and conditions. We have not spoken specifically about rickets, so I will ensure that we do that at our next meeting.

The Convener: Gillian Mackay has questions in our next theme.

Gillian Mackay (Central Scotland) (Green): It is being reported in the press this morning that the UK Government is likely to announce a ban on disposable vapes in the coming weeks. I welcome the Scottish Government's commitment to a consultation on banning them. However, harm is still occurring while that work is under way. Many vaping products are displayed in shop windows alongside sweets, or at the end of aisles, in full view of children and young people. I wrote to retailers, asking them to proactively put vapes behind cover, but many declined, saying that they will comply with any legislation that is introduced. The Scottish Government plans to use its current regulation-making powers to move quickly to put vaping products out of sight—in particular, out of the sight of children. Are additional measures, such as plain packaging or restriction of advertising, being considered?

Jenni Minto: We are seeing a hugely worrying situation and we are doing a number of strands of work in the area. Just last week, at a round-table event that was co-hosted by Lorna Slater, there was a discussion, from an environmental perspective, on the impact of single-use vapes. I also have a meeting this Saturday with young children. At the round-table meeting, there was real strength of feeling that we need to consult younger people more about the best thing to do.

10:15

We are building on regulations that are already in place and we are reviewing promotion and sale of vapes to under-18s to ensure that we have the right processes in place. We consulted in, I think, 2022 on restrictions on advertising and promotions, and we are looking at that as well. Much work is on-going, and I am working closely with my officials to ensure that we make the proportionate and right response to the current situation with regard to vapes.

Gillian Mackay: Is work under way on putting vapes behind covers, as currently happens with cigarettes? One of the biggest concerns that we are hearing from parents is about the pervasiveness of the products, especially in shops. They can be reached by toddlers, because they are on the ends of aisles in some shops. If that was happening with cigarettes, we would rightly be outraged: vapes contain the same addictive ingredient. Is consideration being given to putting vapes behind covers?

Jenni Minto: As you will know, the tobacco action plan will come out this autumn, and it absolutely will consider vapes and where they are in shops. As you have, I have heard stories about the experiences of mothers in supermarkets, where vapes are at eye level for children and have bright colours that attract them. We are very aware of that situation, and it will be covered in the tobacco action plan.

Gillian Mackay: Yesterday, I hosted a round-table meeting that was attended by Emma Harper and other colleagues. We heard from paediatricians and parents who are concerned about the addiction that children are currently suffering and the potential long-term health impacts. We have never needed large-scale nicotine cessation therapies for children before, but that is potentially looming. Many of the nicotine-replacement therapies that we currently have are licensed only for children aged 12 and over, but we have anecdotally heard about children as young as eight using vapes who might need support. What work is under way to develop pathways and support and advice for young people and parents who are facing such addiction?

Jenni Minto: I would be really interested to get the read-out from the meeting that you chaired yesterday. There was quite a bit in that question. Ideally, the approach would be through prescriptions, but there are currently no such products that are approved by the Medicines and Healthcare products Regulatory Agency. However, we are looking into the matter and I am working with my officials in pharmacy and suchlike.

Sandesh Gulhane: I have a question on alcohol. The Turning Point Scotland 218 service in Glasgow, which supports female offenders to rebuild their lives after drug and alcohol use, is facing £850,000 in cuts. The 218 service is primarily funded by the Scottish Government. Can

you explain the rationale for cutting that vital service, and can you commit to restoring funding for it?

Michael Matheson: I know the 218 service from my time in the justice portfolio. It is not funded under the health portfolio; if I recall correctly, it is funded directly through the community justice programme. I know that the Cabinet Secretary for Justice and Home Affairs has been engaged on that matter. I think that the issue was raised in Parliament and that she said that she would engage on it. That was in relation to community justice funding that was having an impact.

Christine McLaughlin can say a bit more about that.

Christine McLaughlin (Scottish Government): I cannot fully answer Mr Gulhane's question. We can follow up with detail, but I know that there have been previous discussions about Turning Point as an organisation. As the cabinet secretary said, the majority of the organisation's funding comes through justice, although there is a small proportion relating to alcohol and drugs services, as Mr Gulhane said. We can take the question away and will provide a response to the committee to give members an understanding of what the service's budget is now compared to what it has been, and for what services it was provided.

Sandesh Gulhane: Thank you very much. I want to follow up what Gillian Mackay asked about vaping. My real concern, which is huge, is about the number of kids who vape. They openly vape—it is not like having a cigarette behind the bike shed. They vape walking down the street and in schools. Toilets are like vaping rooms, and kids hide the vapes in the lights, which is hugely worrying.

I know that you said that work is under way, but when will we hear about concrete things that can be put into place to stop under-18s buying vapes? It is illegal already, but trading standards simply cannot cope. We really need something to be done.

Jenni Minto: That is a fair question. When I was visiting a school in my constituency, a teacher came out with eight brightly coloured vapes in her hand.

I absolutely agree that we are in a very difficult situation. As you have rightly pointed out, it is already illegal to sell vapes to under-18s. We have discussed that with our local authorities to ensure that they recognise that. However, as I mentioned to Ms Mackay, the tobacco action plan is coming out this year.

Paul Sweeney (Glasgow) (Lab): We have had a lot of correspondence from members of the public as a result of our call for feedback on the state of the national health and social care system and mental health in Scotland, particularly on waiting times for child and adolescent mental health services. Waiting times data for the most recent quarter shows that 73.8 per cent of children and young people were seen by CAMHS within 18 weeks. That figure is lower than that for the previous quarter, and it falls short of the Scottish Government's target of 90 per cent of people being seen within 18 weeks. I understand that the delivery plan for the mental health strategy will look at when boards can reach the waiting times standard, but will that plan be accompanied by funding so that health boards can build the required capacity to meet that target effectively?

Michael Matheson: CAMHS have expanded enormously over a number of years, but demand for them has also increased significantly. I recognise the concerns that Paul Sweeney has raised about children's and families' unnecessary waits to access some of those services. The intention behind our delivery plan is to ensure that there is a much more consistent approach to how services are delivered across the country. Members will be aware that some boards are performing better than others on service delivery, but there is a need to achieve greater consistency.

I cannot give a commitment on the funding aspect at this stage because we are going into the budget round for next year and we will need to see what the budget settlement is. However, we need to continue to expand and develop our CAMHS as a priority. I know that the Minister for Social Care, Mental Wellbeing and Sport, Maree Todd, spends a lot of time trying to ensure that we are taking the right approach to getting greater consistency of service delivery across the country, because variation of service provision is one of the biggest challenges that we face around CAMHS. The objective behind the delivery plan is to ensure that there is greater consistency of approach.

Paul Sweeney: Could you tell us a bit more about the mechanisms that you are looking to deploy to ensure greater consistency and reduce variation? What specific operational changes do you propose to make?

I recognise that you cannot commit to specific funding at this stage, given that it is not necessarily in your gift alone as the cabinet secretary, but there is the broader objective of allocating at least 10 per cent of expenditure to mental health, as set out in your party's manifesto and the Bute house agreement. Is the end of the current parliamentary session still the target? Will there be a commitment to that 10 per cent target, or will there be a proposed cut in real terms to the mental health budget?

Michael Matheson: On your latter point, it is still our objective to achieve the 10 per cent target within the current parliamentary session and to take that forward over the next three years.

I do not have the information on the specific measures that you asked about to hand, but I would be more than happy to come back to the committee to give it some more detail about specific measures that we are looking to take to address the consistency of service provision.

The Convener: Before I ask my next question, I declare an interest, in that I am a mental health nurse registered with the Nursing and Midwifery Council. Also, I commissioned the review as Minister for Mental Health.

What recommendations will the Scottish Government be taking forward from the mental health law review and can you give a timeframe for that? What work is under way to review mental health legislation?

Michael Matheson: John Scott made a range of recommendations in his report, and we accepted all the key ones. Implementing some of them will require changes to primary legislation and I hope that we can aim to introduce primary legislation during the current parliamentary session to give effect to some of the measures that will be needed to do that.

The Convener: We now move to questions from Emma Harper.

Emma Harper: I thought that someone else was going to kick off on this topic.

The Convener: Okay—I call Paul Sweeney.

Paul Sweeney: The recruitment crisis in social care is another major issue that has been fed back strongly to the committee. The programme for government included a commitment to a pay rise to £12 per hour for social care staff. If the Government had acted when calls for the rise to £12 per hour were made three years ago, that increased level would now be worth almost £14 per hour, after inflation. Does the cabinet secretary think that that is sufficient to address the scale of the recruitment and retention issues in social care, bearing in mind the opportunity cost of not acting?

Michael Matheson: No—it will not be sufficient. It is one aspect. Part of the challenge around social care comes from the fact that we, as a society, have not valued it as much as we value other professional groups, particularly when comparing social care with health. That is a wider societal issue, which we have to be honest and open about, but the consequences of not valuing social care are now clear, given the challenge that it now faces.

Pay is one part of the matter. The other important aspect is to see social care as a career of choice, with a career pathway and progression and opportunities stemming from that. We are exploring whether we could do more to create career pathways in social care, to encourage people to go into it and build up experience within it, and to pursue opportunities to go into other professional groupings.

One area of work that we are considering is the potential creation of pathways into regulated professions, perhaps through approaches such as the nursing apprenticeship model, so that someone's extensive experience in social care will allow them to progress into some of the regulated professions through a different route from those that are available at present. Creating career pathways is critical to encouraging people to go into social care.

As I say, pay is one part of it, but social care has to be a credible career option for people, and we need to do a lot more around that. Some of the work that we are doing is aimed at encouraging people who are going into social care by providing them with specific routes into other professional groupings if that is what they choose at some point in the future.

Paul Sweeney: I thank the cabinet secretary for that response. The Royal College of Nursing strongly fed back the point that nurses in training felt that they were not able to continue with their studies because of the financial costs. Having an employee status at the outset under an apprenticeship-led model would offer a way of remedying that.

Another major issue that has been fed back is the abolition of non-residential care charges. That was raised very strongly by stakeholders. Non-residential care charges are still in place, with the cost in Glasgow almost doubling. There was no mention of care charges in the programme for government, despite the strain of the cost of living crisis and its impact on some very vulnerable people. Is ending non-residential care charges still a priority for the Scottish Government, or is that not on the radar at the moment?

Michael Matheson: It is still a priority for us, but it is a challenging area of policy to take forward in the existing financial climate. Our options for making more progress on it are limited, largely because of the financial consequences and our not being in a budgetary position where we could actually advance it. It is still a priority and we will progress it should finances become available to allow us to do so, but at present we do not have the financial provision to be able to take it forward.

10:30

Paul Sweeney: Okay. That is disappointing.

Emma Harper: Before I ask my question, I note that I was one of those social care workers who worked in a care home and then progressed to doing nursing training. I became a nurse and was one for 30 years. We should absolutely pursue opportunities for career progression.

The aim of the national care service is to take a standard national approach to the provision of education for care givers. Is that something that we will see as we progress the service so that it doesnae matter where someone is in the country because everyone will be provided with the same level of education, which will allow people to be more mobile in their career pathways?

Michael Matheson: Yes. One of the potential benefits of a national care service is that it will allow us to create more consistent pathways for training and career options for individuals in the social care setting, with opportunities for people to move around the system in a way that they might not be able to do at present.

Part of the challenge is that it social care is a fragmented sector. We have public sector provision, voluntary sector provision and independent sector provision and, despite the fact that there are national standards for care delivery, how they operate often varies. One of the benefits of a national care service would be that we could take a more consistent approach across those three areas, which could help staff with training and potential career routes.

Addressing the fractured nature of the way in which the social care system operates at present is one of the core purposes behind the national care service. It could deliver much greater consistency across the country.

Emma Harper: In the programme for government, there was an announcement about the reopening of the independent living fund. Are you able to speak a wee bit about that?

Michael Matheson: Yes. I am particularly pleased to see that fund reopening because I set it up when I was Minister for Public Health. When the fund was being closed at the UK level, I chose to establish an ILF here in Scotland. Our reopening it—with an initial budget provision of £9 million in the next financial year—will enable us to open it up to around 1,000 additional disabled people who often have much more complex needs.

One of the real strengths of the independent living fund is that it gives individuals, particularly those who have complex care needs, much more control over how their care arrangements are delivered and by whom. I am therefore particularly pleased that we are able to reopen it for new people to apply to it. We are now taking forward the necessary work to put in place arrangements for opening up the independent living fund for individuals in the next financial year.

Emma Harper: You mentioned the voluntary sector in discussing the complexity of the provision of care. The committee often speaks about the third sector as it relates to social prescribing, for example. How does the Government plan to ensure that third sector agencies are supported and viable, given that they are important to the provision of social care services?

Michael Matheson: Some of the additional finance that we are making available for the increase of pay rates, for example, will obviously benefit those organisations in the voluntary sector in relation to the payment of their staff. All parts of social care will benefit if we can retain and recruit staff—the independent, voluntary and public sectors.

We need to make the career environment attractive to individuals, so the rate of pay must reflect that. Would I like to go further on pay in the social care sector? Absolutely. However, we have to operate within the current financial environment. The reality is that £12 per hour is a significant uplift, but going beyond that would create significant financial challenge across the portfolio.

Offering the right pay is one aspect of making the environment attractive to people. As I mentioned in answer to Paul Sweeney, another is creating good career pathways. As you will know from your own pathway, that is critical to supporting not only social care but healthcare in general.

Emma Harper: Convener, do I have time for a quick question about palliative care?

The Convener: No; several other members want to ask questions.

Paul Sweeney: I want to pick up on the work of the COVID-19 Recovery Committee on its inquiry into dentistry services in Scotland. A number of stakeholders are concerned about those. For example, the British Dental Association said that

"uncertainty remains around whether"

the Scottish Government's reform proposals will be enough to

"halt the exodus of dentists from NHS services".

In my own experience, my recent check-up was cancelled for the first time ever because the permanent dentist had left the practice and it was relying on locums to cover appointments.

What is the Scottish Government doing to implement the recommendations of the COVID-19

Recovery Committee's inquiry into NHS dental services, particularly on consideration of costing service model options?

Jenni Minto: We were clear that payment reform was the first step on the journey towards looking at dentistry services. We will collaborate with the BDA and more widely with other dentists on further work on governance and workforce.

I have asked for, and we are arranging, a meeting on dentistry with representatives from the other four UK nations. The issue affects not only Scotland; there are problems with dentistry services across the whole of the UK, partly as the result of a reduction in the number of new dentists coming in. That has happened for two reasons. About 160 student dentists lost a whole year of study because of the pandemic, and then Brexit left us asking how we could encourage dentists from across the world to come to the UK, and to Scotland in particular. A lot of work is being done on that.

I am pleased to say that 183 or 184 students are studying dentistry this year and that will help to move things forward. A lot of work has been done with the directors of dentistry in each of the health board areas to find ways to support dentists who are coming in, specifically in rural health board areas where work similar to that designed to attract GPs is being done. All that work is incredibly positive. My officials and I are engaging with dentists to make progress on it.

Sandesh Gulhane: A constituent of mine, Stuart McGrow, is a dentist who lost his associate during the Covid pandemic. He stepped up to perform more than double his workload to serve patients in his community. However, the funding model did not recognise his individual case, which has meant that he has had to move in with his parents while he tries to keep his practice afloat. Are you willing to consider his case and help him?

Jenni Minto: If you write to me directly, I will be happy to look into the circumstances of that case. As you will know, the Scottish Government has a number of funding streams to support dentistry services, including grants to set up new practices or to employ additional people. Those are dealt with at health board level, but I will be happy to look into the case if you care to write to me about it.

Sandesh Gulhane: Thank you.

I have a second question. I recently visited Possil pharmacy, which is investing in technology to benefit patients. It has automated dispensing machines that allow it to provide out-of-hours prescription collections. It has invested in a robot to help to create blister packs, which many patients are now unable to get help with. Obviously, that is very expensive, but it helps the local community significantly. Would the Scottish Government be able to make money available to help pharmacies that want to invest in those technologies for their communities? Could you create an environment where single pharmacies could group together to do such a thing?

Jenni Minto: I also visited a pharmacy, in Ellon, and saw similar pieces of improved technology to those that you saw in the one that you visited. I was really struck with the importance in the community of community pharmacies. I do not think that a minute went by without somebody in the pharmacy.

The discussion broadened out to some of the areas on which you have touched in your question. I am speaking to officials about ways in which we can work with and support community pharmacies. It goes without saying that the work that they did throughout the pandemic really helped local communities. That work is continuing and it gives people in those communities the opportunity of a much closer, and sometimes more relaxed, interaction with healthcare, which is incredibly important.

Emma Harper: I come back to the national centre for remote and rural healthcare, which will commence next month; I think that an announcement was made on that. My region—South Scotland—is pretty rural and remote all the way down to Stranraer. Where are we with that centre being ready for next month?

Michael Matheson: NHS Education for Scotland will take forward work on the centre, which was announced last week. Given some of the specific challenges that we have in rural areas around the delivery and sustainability of primary care, as Tess White talked about this morning, the first two years of the programme will focus on primary care, which will be the centre's initial priority. The centre will start that work as of October.

Emma Harper: I have a final, quick question. You will obviously be aware of the issue around midwifery in Dumfries and Galloway. Will the rural and remote healthcare centre include midwifery approaches?

Michael Matheson: It will take a holistic approach to consideration of some of the challenges with the delivery of healthcare in rural and remote areas to inform the approach that we should take to address them, and that will include areas such as midwifery as part of its programme. Your constituency is an area in which the centre will particularly be able to work with the local board and the different clinical groupings to try to address some of the challenges that it faces.

The Convener: Sandesh Gulhane wants to come back in.

Sandesh Gulhane: I just want to declare my interest as a practising NHS GP.

Tess White: Cancer waiting times are at their worst level, with 8,000 people waiting for treatment. CAMHS and accident and emergency waiting times are way off your target. One-year waits for outpatients are on-going. Agency staff costs have quadrupled due to the high NHS turnover. There is a new variant of Covid; and you have brought forward the flu vaccination programme. Can we expect the worst winter for the NHS this year?

Michael Matheson: As I said earlier, we are taking forward a programme of work to tackle the backlog and waiting lists, but we can see that significant progress has been made across a range of specialities, and we are working with boards to support and sustain that.

Our healthcare system is experiencing challenges with the recruitment of staff in the same way that the health system across the UK is experiencing real difficulties. Some specialities are not just causing difficulties for the UK; there are global challenges because of the lack of specialists in those areas. However, we are taking things forward. For example, the fill rate in our speciality recruitment programme is at 93 per cent, which is a higher fill rate at this point of the cycle than we have ever been at previously. We have another fill rate to go, and it will be finalised in November, so we are making very good progress towards being an attractive location for clinicians to come for training and support.

Our NHS, however, will experience very significant challenges this winter. What are we doing to address that? We are expanding things such as the hospital at home service and see-and-treat programmes with the Scottish Ambulance Service. We are working closely with our health boards on the preparations that they are putting in place for their A and E departments, which often feel the brunt of these challenges.

10:45

We started our winter planning programme earlier than ever before. One of the first pieces of work I commissioned when I took over the portfolio was our winter programme, given the very challenging winter that we went through last year. We have taken forward that planning jointly with the Convention of Scottish Local Authorities and, just a few weeks ago, we had a winter summit that brought together all the key stakeholders in health and social care from across the country with the decision makers to look at planning and managing some of the challenges that we will face in the course of the winter.

It will be a challenging time. I am not going to shy away from that fact and I am not going to kid on that it will not be difficult and that things will be perfect. However, we have brought forward the planning and done it in a joint way that we have never done before to try to mitigate some of the challenges that we face.

You will be aware that we were starting our Covid vaccination and flu vaccination programmes earlier, so some of that was already at an earlier stage than in other parts of the UK. As a result of the new Covid variant, we brought forward the Covid vaccination programme for those who are more vulnerable, but we were always one of the first parts of the UK to move forward with the winter vaccination programme; I got my flu vaccine just yesterday. Anyone here who intends to get the flu vaccine or the Covid vaccine, please take up the offer that is being made.

We are doing what we can to plan for the winter and the challenges that inevitably will lie ahead. We are also trying to put in place programmes of work to deal with the large number of people who continue to wait extended periods for treatment, while we also deal at the same time with the recruitment challenges that are being experienced not just in Scotland but across the whole of the UK, particularly in certain specialities. So far we have made good progress, but we still have to do a lot more.

The Convener: Thank you, cabinet secretary and minister for your attendance, and thank you to your officials. At next week's meeting, we will begin our pre-budget scrutiny for 2024-25. That concludes the public part of our meeting.

10:48

Meeting continued in private until 12:12.

This is the final edition of the *Official Report* of this meeting. It is part of the Scottish Parliament *Official Report* archive and has been sent for legal deposit.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba